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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anna Elizabeth Chiles
2. Dete of Death Month: 5 Dey: 19 Yeer: 98
3. Time of Death: 5:13 PM
4e Facility Name (If not institution, giva street and number): Mariner Health of Overlea
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 213-32-5319
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2 19 05
9. Birthplece (State or Foraign Country): S.C.

Usuel Residence of Decedent

10e. Stete: MD
10b. County: NA
10c. City, Town or Location: BALTIMORE
10d. Insida City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 515 Lyndhurst Street
10f. Zip Code: 21229
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☒ No If Yes, Giva Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Black, Whita, atc.: Specify: Black

15. Decedant's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 9th Grade; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home MAKER
16b. Kind of Business/Industry: Home
17. Fathar's Nema (First, Middla, Last): John Cliuscales
18. Mother's Neme (First, Middle, Maiden Surneme): Sallie Mae Alexander
19e. Informent's Neme/Reletionship (Type, Print): Johnny Jackson-grandson
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 515 Lyndhurst Street, Balto MD 21229
20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Cedar Hill Cemetery
Date: 5-26-98
20c. Location - City or Town, Stete: Glen Burnie, MD
21. Signature of Funeral Service Licensee: Robert March
22. Name and Address of Facility: March F. H. West 4300 Wabash Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximate Interval Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in deeth): e. CONGESTIVE HEART FAILURE — 24 HRS

Due to (or es a consequence of): b. CORONARY ARTERY DISEASE — 10 YEARS

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet Initieted events resulting in death) Last

Due to (or es e consequence of): c.

Due to (or es e consequence of): d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: PERIPHERAL VASCULAR DISEASE

23b. Did tobacco usa contributa to ths causs of death?: 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed?: 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to complation of causa of deeth?: 1☐ Yes 2☐ No

25. Wes case referred to medical examiner?: 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work?: 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and menner es stated. 2☐ Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. Licensa number: D08344
29d. Date signed (Month, Day, Year): 5/28/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 5714 Harford Road 21214

State Registrar

31. Dete filed (Month, Day, Year): MAY 22 1998
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16002

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rodney G. Chaney

2. Date of Death Month: MAY Day: 18 Year: 94

3. Time of Death: 0350

4a. Facility Name *(If not Institution, give street and number)*: Anne Arundel Gen Hosp.

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: AA

Funeral Director

5. Social Security Number: 216 50 8589

6. Sex: XX 1 M 2 F

7. Age *(In yrs. last birthday)*: 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 7, 1948

9. Birthplace *(State or Foreign Country)*: Washington D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Bowie

10d. Inside City Limits: 1 Yes 2 No XX

10e. Street end Number: 12320 Whitehall Drive

10f. Zip Code: 20715

10g. Citizen of What Country?: United States

11. Maritel Stetus: 1 Never Married XX Married 3 Widowed 4 Divorced

12. Wes Decedent Ever in U.S. Armed Forces? XX Yes 2 No If Yes, Give Yeer or Detes: 68/72

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 Yes XX No *Specify:*

14. Rece - Americen Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Police Officer

16b. Kind of Business/Industry: Law Enforcement

17. Fether's Neme *(First, Middle, Last)*: Rodney Calvin Chaney

18. Mother's Name *(First, Middle, Meiden Surneme)*: Annette Harrison

19a. Informent's Neme/Reletionship *(Type, Print)*: Carol Chaney Wife

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 12320 Whitehall Drive Bowie Maryland 20715

20a. Method of Disposition: XX 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: St. Barnabas Church Cemetery Dete: May 22, 1998

20c. Location - City or Town, Stete: Upper Marlboro MD

21. Signature of Funerel Servlce Licensee: James F. Govon

22. Neme end Address of Fecility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert failure. L only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Finel diseese or condition resulting in deeth) e.	Acute Cardiac Arrhythmia	minutes
Due to (or es e consequence of): b.	Acute Myocardial Infarction	UNKNOWN
Sequentielly list conditions, if eny, leeding to Immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting In deeth) Lest Due to (or es e consequence of): c.	Arteriosclerotic Heart Disease	UNKNOWN
d.		

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably XX 4 Unknown

24a. Wes en eutopsy performed? 1 Yes 2 XX No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1 Yes 2 No

25. Wes cese referred to medicel exeminer? 1 XX Yes 2 No

26. Piece of Deeth *(Check only one)*: Hospitel: 1 Inpetient 2 XX ER/Outpetient 3 DOA | Other: 4 Nursing Home 5 Residence 6 Other *(Specify)*

27. Manner of Deeth: XX 1 Neturel 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and manner es stated. XX 2 **Medical Examiner**: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: William P. Jones MD Deputy

29c. License number: D06054

29d. Dete signed *(Month, Dey, Year)*: 5/18/98

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): William P. Jones, MD 695 America 21035

State Registrar

31. Date filed *(Month, Dey, Year)*: MAY 22 1998

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16003

Certificate of Death Reg. No.

Carden, Clarence L
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name *(First, Middle, Last)*: Clarence L. Carden
2. Date of Death Month / Day / Year: May 19, 1998
3. Time of Death: 12:30AM
4a. Facility Name *(If not institution, give street end number)*: Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore
5. Social Security Number: 156-26-1273
6. Sex: X M 2☐F
7. Age *(In yrs. last birthday)*: 62 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG 26, 1935
9. Birthplace *(State or Foreign Country)*: Tennessee

Usual Residence of Decedent

10e. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐Yes X☐No
10e. Street and Number: 1611 Dolittle Rd. Apt. H
10f. Zip Code: 21221
10g. Citizen of What Country?: USA
11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4XDivorced
12. Was Decedent Ever in U.S. Armed Forces? 1XYes 2☐No If Yes, Give Yeer or Dates: Korean Conflict
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2X☐No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 8 / College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Bartender
16b. Kind of Business/Industry: Bar
17. Father's Neme *(First, Middle, Last)*: Morris Carden
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Chloe Berry
19a. Informent's Name/Reletionship *(Type, Print)*: Doris Kemble/sister
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 8307 Stow Rd. Pennsauken, NJ 08110
20a. Method of Disposition: 1☐Burial 2XCremation 3☐Removel from State 4☐Donetion 5☐Other *(Specify)*
20b. Pleca of Disposition *(Name of cemetery, cremetory or other piece)*: Metro Crematory, Inc. — Dete: 5/21/98
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Neme end Address of Fecility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit.

Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0020

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset and Deeth

Immediate Ceuse (Finel disease or condition resulting in deeth)
a. Cirrhosis — 5years
Due to (or es e consequence of):
b. Alcohol Abuse — 20years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Renal Failure
Urinay Tract Infection
Pleural Effusion

23b. Did tobecco use contributa to the ceuse of death? 1☐Yes 2XNo 3☐Probably 4☐Unknown

24a. Was en eutopsy performed? 1☐Yes 2XNo

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2XNo

26. Plece of Death *(Check only one)*: Hospital: 1XInpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1XNatural 2☐Accident 3☐Sulcide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, fectory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1X **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and piece, end due to the cause(s) end menner as stated.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated.

29b. Signeture end title of certifier: DMetz MD
29c. License number: RD 189480
29d. Date signed *(Month, Dey, Year)*: 5/17/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr. Deborah Metz 9000 Franklin Square Drive Baltimore, MD 21237

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1998
32. Registrar's Signature:

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16004

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Rogers Childress

2. Date of Death: Month MAY Day 13 Year 1998

3. Time of Death: 2312

4e. Facility Name (If not institution, give street and number): Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 217-20-0311

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months ___ Days ___

If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): February, 12 1926

9. Birthplace (State or Foreign Country): Ellicott City

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Forest Hill

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 104 East Gwen Drive

10f. Zip Code: 21050

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decadant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): James Rogers

18. Mother's Name (First, Middle, Malden Surname): Elizabeth James

19a. Informant's Name/Relationship (Type, Print): Kathy Foehrkolb / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1305 Marquis Ct. Fallston, Maryland 21047

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Johns Cametery

Date: May 16, 1998

20c. Location - City or Town, Stete: Ellicott City, Maryland

21. Signature of Funeral Service Licensee: [signature] M00535

22. Name and Address of Facility: Slack Funeral Home, P.A. Ellicott City, Maryland 21043

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finai disease or condition resulting in daath)

a. CONGESTIVE HEART FAILURE — 1 YEAR

Due to (or as a consequence of):

b. Aortic Stenosis

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disaase or injury that initiated evants resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilebie prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatiant 2☒ ER/Outpetient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at tha tima, data and piace, and dua to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the causa(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D 08096

29d. Date signed (Month, Day, Year): MAY 14, 1998

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): ANDREW NOWAKOWSKI MD 125 N. MAIN ST BEL AIR Md 21014

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Childress, Elizabeth

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed (Month, Day, Year): MAY 22 1998

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Item#12 perFH G759 5/22/98 EW

Reg. No. 98 16005

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William C. Childress

2. Date of Death — Month: May; Day: 16; Year: 1998

3. Time of Death: 9:06 Am

4a. Facility Name *(If not institution, give street and number)*: Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 220-14-1083

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 72 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 16, 1926

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick County

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 122 New Castle Court

10f. Zip Code: 21702

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates: 1944-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner - Forest Diner

16b. Kind of Business/Industry: Restaurant

17. Father's Name *(First, Middle, Last)*: Dillard M. Childress

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillie Lowman

19a. Informant's Name/Relationship *(Type, Print)*: Kathy Foehrkolb

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1305 Marquis Court, Fallston, Maryland 21047

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Johns Caretery — Date: May 19, 1998

20c. Location - City or Town, State: Ellicott City, Maryland

21. Signature of Funeral Service Licensee: [signature] M00535

22. Name and Address of Facility: Slack Funeral Home, P.A. Ellicott City, Maryland 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Subdural hematoma

Poss. lung cancer

Syndrome of inappropiate antidiuretic homone

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D50973

29d. Date signed *(Month, Day, Year)*: May 16, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACOB SHERMAN, Patuxent Med Group, Two Knoll North DR. Columbia MD 21045

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16006

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANILKUMAR DOSHI

2. Date of Death Month: MAY Day: 19 Year: 1998

3. Time of Death: 1523

4a. Facility Name *(If not institution, give street and number)*: THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death:

Funeral Director

5. Social Security Number: 578-76-2327

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 60 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 13, 1937

9. Birthplace *(State or Foreign Country)*: India

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George

10c. City, Town or Location: Beltsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4914 Lexington Avenue

10f. Zip Code: 20705

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Indian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Estimator

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Prabhudas Gangadas Doshi

18. Mother's Name *(First, Middle, Maiden Surname)*: Kamalaben Puishottamdas Mehta

19a. Informant's Name/Relationship *(Type, Print)*: Prashant Doshi/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4914 Lexington Avenue, Beltsville, Maryland 20705

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Baltimore Washington Cr.

Date: 5/23/98

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Steven H. Williams

22. Name and Address of Facility: Fleck Funeral Home, Inc. 7601 Sandy Spirng Road, Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS — 3 WEEKS

Due to (or as a consequence of): b. LIVER FAILURE — 2 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mark J. Baskerville MD

29c. License number: RES-000

29d. Date signed *(Month, Day, Year)*: MAY 19, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARK J. BASKERVILLE MD 630 North Wolfe Street Baltimore, Maryland 21287

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit.

98-2828-047
CMK
DAVID DAWSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16007

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DAVID JOSEPH DAWSON
2. Date of Death (Month, Day, Year): MAY 18, 1998
3. Time of Death: 2044PM
4a. Facility Name (If not institution, give street and number): ATLANTIC GENERAL HOSPITAL
4b. City, Town, or Location of Death: BERLIN
4c. County of Death: WORCESTER COUNTY

Funeral Director

5. Social Security Number: 145-40-2264
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 4, 1947
9. Birthplace (State or Foreign Country): TRENTON, N.J.

Usual Residence of Decedent

10a. State: N.J.
10b. County: MERCER
10c. City, Town or Location: HAMILTON TOWNSHIP
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 43 CUNNINGHAM AVE.
10f. Zip Code: 08610
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CORRECTIONS OFFICER
16b. Kind of Business/Industry: N.J. DEPT. OF CORR'NS

17. Father's Name (First, Middle, Last): JAMES DAWSON JR.
18. Mother's Name (First, Middle, Maiden Surname): CLARA VIRGINIA SICILIANO

19a. Informant's Name/Relationship (Type, Print): BETTY ANNE DAWSON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 583 S. MOUNT VERNON CIRCLE BENSALEM, PA. 19020

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): GREENWOOD CEM. Date: MAY 23 1998
20c. Location - City or Town, State: HAMILTON TOWNSHIP NJ

21. Signature of Funeral Service Licensee: Thomas J. Skarda Jr.
22. Name and Address of Facility: SKARDA F.H. 2829 HUDSON ST. BALTIMORE, MD 21224

Physician /Medical Examiner

23a. Part1. Enter the disease or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease
Due to (or es e consequence of):
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last: b.
Due to (or as a consequenca of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant condftfons** contributing to death but not resulting in the underlying cause given in Part I.

23b. Dfd tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medicat examiner? 1 [X] Yes 2 [ ] No
26. Place ot Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date ot Injury (Month, Dey Yeer)
28b. Time of injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as steted. 2 [X] **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: Clayton Locke MD
29c. License number: O.C.M.E.
29d. Dete signed (Month, Day, Year): MAY 20, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CLAYTON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16008

DAWSON, DAVID
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DAVID DUNN DAWSON
2. Date of Death: Month MAY Day 19 Year 98
3. Time of Death: 1705
4a. Facility Name (If not institution, give street and number): UNION HOSP. OF CECIL CO.
4b. City, Town, or Location of Death: ELKTON
4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 199-26-4625
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 61 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 14, 1937
9. Birthplace (State or Foreign Country): PA.

Usual Residence of Decedent

10a. State: PA
10b. County: BUCKS
10c. City, Town or Location: WARRINGTON
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 1211 FOAL CIRCLE
10f. Zip Code: 18976
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ELECT. CONTRACTION
16b. Kind of Business/Industry: ELECTRIC CO.

17. Father's Name (First, Middle, Last): JAMES DAWSON
18. Mother's Name (First, Middle, Maiden Surname): AGNES DUNN

19a. Informant's Name/Relationship (Type, Print): LYNN INVERSO
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 1211 FOAL CIRCLE WARRINGTON, PA. 18976

20a. Method of Disposition: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): R.A. FERRIS CREMATORY
Date: MAY 22 1998
20c. Location - City or Town, State: WEST CHESTER, PA.

21. Signature of Funeral Service Licensee: Thomas J. Skarda Jr.
22. Name end Address of Facility: SKARDA FH. 2829 HUDSON ST. BALTO., MD. 21224

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

		Approximete Interval Between Onset and Deeth
Immediate Cause (Finel disease or condition resulting in death) a.	Acute Congestive Heart Failure	Hours
Due to (or as a consequence of) b.	Severe Acute Anemia	Hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet Initiated events resulting in death) Last — Due to (or as a consequence of): c.	Bleeding Perforated Gastric Ulcer	Days
Due to (or as a consequence of): d.	Hepatic Cirrhosis	Days

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 X No
24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and placa, and due to the ceuse(s) end manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) end manner stated.

29b. Signature and title of certifier:
29c. License number: D47711
29d. Date signed (Month, Day, Year): May 20, 1998

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): David Gar-El 3 Mauldin Avenue North East Maryland 21901

State Registrar

31. Date filed (Month, Day, Yeer): MAY 22 1998
32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

98-2713-510

ROBERT DOYLE

ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I,II,27 per MEO G-760 6/16/98 — *Certificate of Death* — Reg. No. 98 16009

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Wayne Doyle
2. Date of Death: Month MAY Day 14 Year 1998
3. Time of Death: 6:00 A
4a. Facility Name (If not institution, give street and number): 1929 FREDERICK AVE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-64-4207
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 43 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 27, 1955
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1929 Frederick Avenue
10f. Zip Code: 21223
10g. Citizen of What Country?: USA
11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales Clerk
16b. Kind of Business/Industry: Department Store
17. Father's Name (First, Middle, Last): Francis T. Doyle
18. Mother's Name (First, Middle, Maiden Surname): Margaret Eleanor Golden
19a. Informant's Name/Relationship (Type, Print): Francis T. Doyle/father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 300 E. Church St. Orlando, FL 32801
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.
Date: 5/16/98
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: Dawn F. McDonald — Dawn F. McDonald
22. Name and Address of Facility: Cremation Society of Maryland Inc. 299 Frederick Road Baltimore, MD 21228

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CAROIAC ARRHYTHMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: SCHIZOPHRENIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [✓] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Date of Injury (Month, Day Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J. Chute MD

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): MAY 14, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

1

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16010

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Doris R. Delawder

2. Date of Death Month Day Year: May 16, 1998

3. Time of Death: 7:40am

4a. Facility Name (If not institution, give street and number): 5486 Oakland Road

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-20-9828

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 2, 1925

9. Birthplace (State or Foreign Country): Ellicott City

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore County

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 5486 Oakland Road

10f. Zip Code: 21227

10g. Citizen of What Country? USA

11. Maritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: Spring Grove Hospital

17. Father's Name (First, Middle, Last): Harvey Fauver

18. Mother's Name (First, Middle, Maiden Surname): Mildred Issacs

19a. Informent's Neme/Relationship (Type, Print): James Delawder / Spouse

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5486 Oakland Road, Baltimore, Maryland 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): Crestlawn Cemetery

Dete: May 19, 1998

20c. Location - City or Town, State: Marriottsville, MD

21. Signature of Funerel Service Licensee: [signature] MO0535

22. Neme end Address of Facility: Slack Funeral Home, P.A. Ellicott City, Maryland 21043

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death): e. Metastatic Breast Cancer — 3.5 yrs

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Insulin dependent diabetes mellitus
Coronary Artery disease
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☒ No

28. Piece of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end manner as stated. 2☐ Medical Examiner: On the basis of exemination end/or investigetion, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Barbara Socha, MD

29c. License number: D35609

29d. Dete signed (Month, Day, Year): 5/18/98

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Barbara Socha 516 N. Rolling Rd. Suite 108 Baltimore, MD 21228

State Registrar

31. Dete filed (Month, Day, Year): MAY 22 1998

32. Registrer's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16011

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ruby Phillips Eisinger

2. Date of Death (Month, Day, Year): May 15 1998

3. Time of Death: 8:45 A.M.

4a. Facility Name *(If not institution, give street and number)*: Villa Rosa Nursing Home

4b. City, Town, or Location of Death: Mitchellville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579 03 5300

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 3, 1907

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Virginia

10b. County: Fairfax

10c. City, Town or Location: Fairfax Station

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 8930 Harrivan Lane

10f. Zip Code: 22039

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Postal Worker

16b. Kind of Business/Industry: U.S.P.S.

17. Father's Name *(First, Middle, Last)*: John Bailey Phillips

18. Mother's Name *(First, Middle, Maiden Surname)*: Sallie May Rittenhouse

19a. Informant's Name/Relationship *(Type, Print)*: Roger Lynn Eisinger Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8930 Harrivan Lane Fairfax Stations Virginia 22039

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Hill Cemetery | Date: May 18, 1998

20c. Location - City or Town, State: Suitland Maryland

21. Signature of Funeral Service Licensee: James K Jervon

22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thong

29c. License number: D 19591

29d. Date signed *(Month, Day, Year)*: 5/15/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thong Limpuangthip MD 221 Bellepoint Dr. Greenbelt MD 20770

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1998

32. Registrar's Signature: Julia Davidson-Randall

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16012

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BEATRICE E. EDLOVITCH

2. Date of Death (Month, Day, Year): May 19, 1998

3. Time of Death: 7:30 A.M.

4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-16-0848

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 23, 1920

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 430 Bostwick Lane

10f. Zip Code: 20878

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk Typist

16b. Kind of Business/Industry: U.S. Government

17. Fathar's Nama (First, Middle, Last): Edward Elansky

18. Mothar's Name (First, Middla, Meiden Surnema): Fannie (Unknown)

19a. Informant's Name/Relationship (Type, Print): Fran Edlovitch, Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 430 Bostwick Lane, Gaithersburg, Maryland 20878

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Judean Memorial Gardens Date: 5/20/1998

20c. Location - City or Town, State: Olney, Maryland

21. Signature of Funeral Service Licensea: ▶ Donald C. Stottlemyer

22. Name and Address of Facility: STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onsat and Death

Immediate Causa (Final disaese or condition resulting in death): a. ACUTE STROKE — 3 WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet Initieted events resulting in death) Last:

b. HYPERTENSION

Due to (or as a consequence of):

c. DIABETES MELLITUS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of exemination end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Jonathan S. Plotsky M.D.

29c. Licensa number: D38589

29d. Data signed (Month, Dey, Year): May 19, 1998

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Jonathan S. Plotsky, M.D., 15225 Shady Grove Road, Rockville, Maryland 20850

State Registrar

31. Date tiled (Month, Dey, Year): MAY 22 1998

32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16013

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Erbe

2. Date of Death (Month, Day, Year): May 18, 1998

3. Time of Death: 5:10am

4a. Facility Name (If not Institution, give street and number): St. Agnes Rehabilitation Center

4b. City, Town, or Location of Death: Ellicott City

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 215-01-4983

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): January 15, 1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore County

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7938 St. Gregory Drive

10f. Zip Code: 21222

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Henry Ebel

18. Mother's Name (First, Middle, Maiden Surname): Dorathea Reichmuller

19a. Informant's Name/Relationship (Type, Print): Roger Erbe

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11900 Hunters Run Dr. Hunt Valley, Maryland 21030

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens

Date: May 20, 1998

20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: [signature] M00535

22. Name and Address of Facility: Slack Funeral Home, P.A. Ellicott City, Maryland 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Respiratory Distress	1 day
Due to (or as a consequence of):	b. Colon Cancer	4 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Steven Geller MD

29c. License number: 034613

29d. Date signed (Month, Day, Year): May 18, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Geller MD 9501 Old Annapolis Rd Ellicott City MD 21042

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998

32. Registrar's Signature: [signature] Julie Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16014

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ERNEST N. FARLEY JR.
2. Data of Death Month: 5 Day: 20 Yaar: 98
3. Time of Death: 10:45 AM
4a. Facility Name *(If not institution, giva street and number)*: 460 Kenilworth Court
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel Co.

Funeral Director

5. Social Security Number: n 217-56-3501
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Yaar)*: Nov. 28 1951
9. Birthplace *(State or Foreign Country)*: W. Virg.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.
10b. County: Anne Arundel Co.
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1 [ ] Yas 2 [X] No
10e. Street and Number: 460 Kenilworth Court
10f. Zip Code: 21061
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Merried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Dacedant Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver
16b. Kind of Business/Industry: Felmor Corp.

17. Fathar's Name *(First, Middla, Last)*: Ernest N. Farley Sr.
18. Mother's Name *(First, Middle, Maiden Surnama)*: Cornelia Helmick

19a. Informant's Name/Ralationship *(Typa, Print)*: Cynthia A. Farley Wife
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 460 Kenilworth Court Glen Burnie, Md. 21061

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Glen Haven Memorial Pk.
Date: May 23 1998
20c. Location - City or Town, State: Glen Burnie, Md.

21. Signature of Funeral Service Licensee: ▶ John F. Collins
22. Name and Address of Facility: McCully-Polyniak Funeral Home 3204 Mountain Road, Pasadena, Md. 21122

Physician /Medical Examiner

23a. Part I. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in deeth)
a. probable Myocardial Infarction
Due to (or as a consequence of):
b. Hyperlipedemia
Due to (or as a consequence of):
c. Coronary artery disease
Due to (or es a consequence of):
d. Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.
Chronic lower Abdominal pain
Morbid Obesity

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residanca 8 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred
28e. Placa of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated. 2 [ ] **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier: ▶ Shobha Reddy MD
29c. License number: D30568
29d. Data signed *(Month, Day, Year)*: 5-21-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. SHOBHA P. REDDY 7845 OAKWOOD RD. STE 204 Glen Burnie Md. 21061

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 22 1998
32. Registrar's Signature: ▶ Judy Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16015

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): HARRY EDWARD FAILING, SR
2. Dete of Death Month: MAY Dey: 18 Year: 1998
3. Time of Death: 0945
4e. Feciility Neme (If not institution, give street end number): St. Agnes Hospital
4b. City, Town, or Location of Deeth: Baltimore
4c. County of Death: N/A

Funeral Director

5. Socie! Security Number: 212-34-4717
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthdey): 63 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): JUNE 20, 1934
9. Birthplace (Stete or Foreign Country): Maryland

Usuel Residenca of Decedent

10a. Stete: Md.
10b. County: Anne Arundel
10c. City, Town or Location: Jessup
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1856 Montevideo Rd.
10f. Zip Code: 20794
10g. Citizen of Whet Country?: USA
11. Meritei Stetus: 1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorcad
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: WWII
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bieck, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Fire Fighter
16b. Kind of Business/Industry: Baltimore County
17. Fether's Neme (First, Middle, Last): Harry C. Failing
18. Mother's Neme (First, Middle, Meiden Surneme): Dorothy Gamble
19a. Informent's Neme/Reletionship (Type, Print): Mary Failing - wife
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1856 Montevideo Rd., Jessup, Md. 20794
20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removei from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Meadowridge Mem. Park
Dete: 5/21/98
20c. Location - City or Town, State: Elkridge, Md.
21. Signature of Funerel Servica Licensee: [signature]
22. Neme end Address of Feciility: Gary L. Kaufman Funeral Home @ Meadowridge MP 7250 Washington Blvd., Elkridge, Md. 21075

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on eech line.

		Approximate Interval Between Onset and Deeth
Immediete Ceuse (Finel diseese or condition resulting in deeth) e.	ACUTE RENAL FAILURE	FEW DAYS
Due to (or es e consequence of): b.	CIRRHOSIS	FEW YEARS
Sequentieily iist conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted eventa resulting in deeth) Lest — Due to (or es e consequence of): c.	CAD (CORONARY ARTERY DISEASE) WITH CARDIOMYOPATHY	10 YEARS
Due to (or es e consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4■ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2■ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2■ No

25. Wes case referred to medical exeminer? 1☐ Yes 2■ No

26. Place of Deeth (Check only one): Hospitel: 1■ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1■ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer):
28b. Time of Injury: M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1■ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner steted.

29b. Signeture end titie of certifier: Lucia Palladino MD
29c. License number: P11699
29d. Dete signed (Month, Dey, Yeer): MAY 18-1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): PALLADINO LUCIA 900 CATON AVE BALTIMORE, MD

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998
32. Registrar: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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NAME HARRY EDWARD FAILING, SR

10+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16016

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Irving R. Fladung

2. Data of Deeth: Month May Day 19 Yaer 1998

3. Tima of Death: 5:18 A.M.

4a. Facility Nema *(If not institution, giva street and number)*: Doctors' Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 216 16 0484

6. Sex: 1☐M 2☐F (XX)

7. Aga *(In yrs. lest birthday)*: 73 Yrs. | If Under 1 Yeer: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 3 1924

9. Birthplaca *(State or Foreign Country)*: Maryland

Usual Rasidance of Dacedant

10a. Stata: Maryland

10b. County: Prince George's

10c. City, Town or Location: Bowie

10d. Inside City Limits: ☒Yes 2☐No

10e. Street and Number: 14005 Annapolis Road

10f. Zip Code: 20715

10g. Citizan of What Country?: United States

11. Marital Status: 1☐Navar Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Dacedant Evar in U.S. Armed Forcas? ☒Yas 2☐No If Yes, Giva Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- if Yas, specify Cuban, Maxican, Puerto Ricen, atc.): 1☐Yas 2☒No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Dacedant's Education *(Specify only highast grada complated)*: Elementary/Secondary (0-12): 7 | Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Carpenter

16b. Kind of Businass/Industry: Construction

17. Fathar's Nema *(First, Middle, Last)*: Martin E. Fladung

18. Mother's Name *(First, Middle, Maidan Surname)*: Gabriella Kasper

19a. Informant's Name/Relationship *(Type, Print)*: Betty G. Fladung Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Coda)*: 14005 Annapolis Rd. Bowie Maryland 20715

20a. Method of Disposition: 1☐Burial 2☒Cramation 3☐Ramoval from Stata 4☐Donation 5☐Othar *(Specify)*

20b. Place of Disposition *(Name of camatary, crematory or othar placa)*: Metropolitan Crematory Date: May 21, 1998

20c. Location - City or Town, Stata: Alexandria Virginia

21. Signature of Funaral Service Licensee: Jana K Gouri

22. Nama and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter tha disaasa, or complications that ceused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. Lisi only ona causa on aach line.

Approximate Interval Batween Onsat and Death

Immadiata Causa (Final diseasa or condition rasulting in death)
a. Pulmonary Embolli

Due to (or as a consequanca of):
b. Chronic Obstructive Pulmonary Disease

Sequantially list conditions, if any, laading to immadiata ceuse. Enter Underlying Cause (Disaasa or Injury that initiated avants rasulting in death) Last

Dua to (or as a consequance of):
c. Atherosclerotic Cardiovascular Disease

Due to (or es e consequanca of):
d. Peripheral VASCULAR Disease

Part II. **Other significant conditiona** contributing to death but not rasulting in tha underlying cause givan in Part I.

Status Post Laparotomy with lys.s of Adhesions

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Wara autopsy findings available prior to complation of causa of death? 1☐Yas 2☐No

25. Was cesa rafarred to medicei examinar? 1☐Yas 2☒No

26. Placa of Death *(Check only ona)*: Hospital: 1☐Inpatiant 2☒ER/Outpatiant 3☐DOA Othar: 4☐Nursing Homa 5☐Rasidence 8☐Othar *(Specify)*

27. Mannar of Death: 1☒Natural 2☐Accident 3☐Sulcida 4☐Homicida 5☐Panding invastigation 6☐Could not be datermined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐Yas 2☐No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. *(Spacify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, snd dua to the cause(s) and mannar statad.

29b. Signature and title of certifier: Stanley J Crossland M.D.

29c. Licansa number: D21933

29d. Data signed *(Month, Day, Year)*: MAY 20, 1998

30. Nama and address of person who complated causa of daath (Item 23a) (Type, Print): 611 South Carlin Springs Rd Arlington Va. Suite 302

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 22 1998

32. Registrar's Signature: Gina Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16017

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Carl Flynn
2. Date of Death Month May Dey 15 Year 1998
3. Time of Death: 6:42 A.M.
4a. Facility Name (If not institution, give street and number): Heartland Nursing Home
4b. City, Town, or Location of Death: Adelphi
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577 34 2398
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): July 12,1928
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Capitol Heights
10d. Inside City Limits: X☒ Yes 2☐ No
10e. Street end Number: 6900 Valley Park Road
10f. Zip Code: 21743
10g. Citizen of Whet Country? United States

11. Maritel Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: WWII
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Salesman
16b. Kind of Business/Industry: Garage Doors

17. Fether's Name (First, Middle, Last): George Flynn
18. Mother's Neme (First, Middle, Maiden Surname): Mary Humes

19a. Informent's Neme/Relationship (Type, Print): Barbara Flynn Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 6900 Valley Park Road Capitol Heights MD 21743

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): The Huntt Crematory | Dete: May 18 1998
20c. Location - City or Town, State: Waldorf Maryland

21. Signeture of Funeral Service Licensee: Michael L Sigler
22. Name end Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that ceused the deeth. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or haert failure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Deeth

Immediete Ceusa (Final disease or condition resulting in deeth)
e. Arteriosclerotic Cardiovascular Disease — years

Due to (or as a consequence of):
b. Cardiac Arrhythmia — minutes

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted evants resulting in deeth) Lest

Due to (or es e consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus
Chronic Obstructive Lung Disease
Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes cese referred to medical exeminer? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year): N/A
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete end plece, and due to the cause(s) end menner stated.
29b. Signeture end title of certifier: Paul A DeVore MD
29c. License number: D01852
29d. Date signed (Month, Dey, Year): May 18 1998
30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): PAUL A DEVORE MD 4203 Queensbury Rd Hyattsville MD 20781

State Registrar

31. Dete filed (Month, Dey, Year): MAY 22 1998
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16018

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy Farrell

2. Date of Death Month / Day / Year: May 17 1998

3. Time of Death: 6:00 A.M.

4a. Facility Name (If not institution, give street and number): 12305 Welling Lane

4b. City, Town, or Location of Death: Bowie

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 466 50 1222

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 12, 1906

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Goerge's

10c. City, Town or Location: Bowie

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street and Number: 12305 Welling Lane

10f. Zip Code: 20715

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced ☒

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Piano Teacher

16b. Kind of Business/Industry: Music

17. Father's Name (First, Middle, Last): Alexander Henneman

18. Mother's Name (First, Middle, Maiden Surname): Isabella Cornet

19a. Informant's Name/Relationship (Type, Print): Edward Cassidy Son-In-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1309 Magnolia Ave. Annapolis Maryland 21403

20a. Method of Disposition: ☒ 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart Church Cemetery Date: May 20, 1998

20c. Location - City or Town, State: Bowie Maryland

21. Signature of Funeral Service Licensee: Michael L Byrd

22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic heart disease. 1 year

Due to (or as a consequence of):

b. Arrhythmia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: P 34403

29d. Date signed (Month, Day, Year): 5/18/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Dibin 3201 Superior Ln Bowie MD 20715

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16019

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Domicela Katherine Frys

2. Date of Death: Month: May; Day: 16; Year: 1998

3. Time of Death: 4:12 PM

4a. Facility Name (If not institution, give street and number): Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 214-30-6410

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months: ; Days:

If Under 24 Hrs.: Hours: ; Min.:

8. Date of Birth (Month, Day, Year): May 6, 1911

9. Birthplace (State or Foreign Country): Poland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Kingsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11907 Caspion Road

10f. Zip Code: 21087

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specity Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed)

Elementary/Secondery (0-12): 12 yrs.

College (1-4or 5+): n/a

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Homekeeper

17. Father's Name (First, Middle, Last): Joseph Kudlacik

18. Mother's Name (First, Middle, Melden Surneme): Maria Orlicki

19a. Informent's Name/Relationship (Type, Print): Mrs. Josephine M. Duffy (Daughter)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 11907 Caspion Road Kingsville, Maryland 21087

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Placa of Disposition (Neme of cemetery, cremetory or other piece): Gardens of Faith Cemetery

Date: 5/19/98

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: E. F. Lassahn

22. Name end Address of Facility: E. F. Lassahn Funeral Home, 11750 Belair Road Kingsville, Md. 21087

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Final diseese or condition resulting in death) e. aspiration pneumonia

Due to (or as e consequenca of):

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last

b.

Due to (or es e consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying ceuse given in Part I.

seizure disorder

diabetes

hypothyroidism

23b. **Did tobacco use contributs to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings evallable prior to completion of cause of deeth? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Wes case reiferred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Phyaician**: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) and manner as stated. 2☐ **Medical Examinar**: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and piece, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Thomas Gamelin MD

29c. License number: D37364

29d. Dete signed (Month, Dey, Year): May 16, 1998

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): 19 Walnut Lane, Aberdeen, Maryland

State Registrar

31. Date filed (Month, Dey, Year): MAY 22 1998

32. Registrar's Signature: Jackie Davidson-Randall

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Domicela Katherine Frys

4

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gloria L. Frank

2. Date of Death (Month, Day, Year): MAY 20, 1998

3. Time of Death: 2:35PM

4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: A.A. COUNTY

Funeral Director

5. Social Security Number: 216-34-4032

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 14, 1938

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 103 2nd Ave., S.E.

10f. Zip Code: 21061

10g. Citizen of What Country?: United States

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Wilbur B. Warfield

18. Mother's Name (First, Middle, Malden Surname): Dorothy Eschenbach

19a. Informant's Name/Relationship (Type, Print): Richard J. Frank / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 103 2nd Ave., S.E., Glen Burnie, MD 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Glen Haven Mem. Pk.

Date: May 23, 1998

20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)

a. Pancreatic Cancer metastatic — 8 months

Due to (or as e consequence of):

b. To Lymph Node and Peritoneum

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

Due to (or as a consequenca of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) end manner steted.

29b. Signeture end title of certifier: [signature] Mayer Gorbatyuk MD

29c. License number: D27938

29d. Date signed (Month, Day, Year): 5/20/98

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Mayer Gorbatyuk MD. 795 Aquahart Rd Glen Burnie MD 21061

State Registrar

31. Dete filed (Month, Day, Year): MAY 22 1998

Registrar's Signature: [signature] Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

FRANK Gloria

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item:20b per F.H. G-759 5/27/98 reb

Certificate of Death

Reg. No. 98 16021

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
SHREA V. FRIESON	MAY 20, 1998	9 pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3467 MAYFIELD AVENUE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex 1☐M 2☐F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-86-6012	X	25			SEPT. 19, 1972	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3467 MAYFIELD AVE.	21213	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: NEGRO

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12TH	N/A	CERTIFIED MEDICINE AID	NURSING HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
HAROLD FRIESON	CAROLYN DEAN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
CAROLYN DEAN / MOTHER	3467 MAYFIELD AVENUE BALTO, MD. 21213

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cramation 3☐Removal from State 4☐Donation 5☐Other (Specify)	BALTIMORE CEMETERY ~~MAY 28, 1998~~	5/27/98	BALTIMORE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Calvin B. Scruggs Sr.	CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO, MD. 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or haart failure. List only one cause on each line.

		Approximate Intervet Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. AIDs	
	Due to (or es a consequence of):	
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. CNS Lymphoma	
	Due to (or es e consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cryptocal Meningitis

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1☐Yes 2☑No 3☐Probably 4☐Unknown	1☐Yes 2☑No	1☐Yes 2☑No

25. Was cese referred to medicel examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Homa 5☑Residence 6☐Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end piece, end due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, deeth occurred at tha time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MHolmes MD	D46676	May 21, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michaelle Holmes MD
3301 Belair Road Baltimore, MD 21213

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 1998	▶ Julia Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

4

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16022

Item#7 per FH G759 5/22/98 EW

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James H. Floyd

2. Data of Death — Month: MAY Day: 18 Year: 1998

3. Time of Death: 15:20

4a. Facility Name (If not institution, give street and number): Saint Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 212-07-8335

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): ~~88~~ 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): November 16, 1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Marriottsville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 11110 Douglas Avenue

10f. Zip Code: 21104

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: 1944-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Building Inspector

16b. Kind of Business/Industry: Howard County Government

17. Father's Name (First, Middle, Last): James Henry

18. Mother's Name (First, Middle, Maiden Surname): Dorothy Kraft

19a. Informant's Name/Relationship (Type, Print): Geraldine Floyd/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11110 Douglas Avenue, Marriottsville, Maryland 21104

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Cemetery — Date: May 22, 1998

20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: [signature] M00535

22. Name and Address of Facility: Slack Funeral Home, P.A. Ellicott City, Maryland 21043

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION — 20 MIN

Due to (or as a consequence of):
b. BLADDER CANCER — 6 MON.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Medical Resident

29c. License number: A 10885

29d. Date signed (Month, Day, Year): 05/18/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RIZWAN SAFDAR; ST. AGNES HOSPITAL, 900 CATON AVENUE, BALTIMORE, MD 21229

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Floyd James

17

18

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16023

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John E. Gibson
2. Date of Death Month: MAY Day: 19 Year: 98
3. Time of Death: 0534
4a. Facility Name (If not institution, give street and number): Anne Arundel Gen. Hospital
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: A A

Funeral Director

5. Social Security Number: 214-50-0456
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 50 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 28 1947
9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Decedant

10a. State: Md.
10b. County: Anne Arundel Co.
10c. City, Town or Location: Severna Park
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 108 Arundel Road
10f. Zip Code: 21146
10g. Citizan of What Country?: USA

11. Maritel Status: 1 [ ] Naver Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Dacedent Evar in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - Americen Indian, Black, White, atc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Draftsman
16b. Kind of Business/Industry: Northrop Grumman

17. Fether's Nema (First, Middle, Last): John William Gibson Sr.
18. Mother's Name (First, Middle, Maiden Surname): Alma Ruth Eidman

19a. Informant's Name/Relationship (Type, Print): Jessie L. Gibson Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 108 Arundel Road Severna Park, Md. 21146

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Pk. Date: May 22 1998
20c. Location - City or Town, Stete: Glen Burnie, Md.

21. Signature of Funaral Service Licensee: Alan C. Dunn
22. Name and Address of Facility: McCully-Polyniak Funeral Home 130 E. Fort Ave. Baltimore, Md. 21230

Physician /Medical Examiner

23e. Part I. Enter tha disaasa, or complications that ceusad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only one cause on aach lina.

Approximate Interval Between Onsat and Death

Immediata Causa (Final disaasa or condition resulting in death):
a. Arteriosclerotic Heart Disease — UNKNOWN
Due to (or as a consaquance of):
Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Diseasa or Injury thet initiated evants rasulting in death) Last
b.
Dua to (or as a consequance of):
c.
Due to (or es e consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Wara autopsy findings available prior to completion of ceuse of death? 1 [ ] Yas 2 [X] No

25. Wes cesa referred to medical examiner? 1 [X] Yas 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatiant 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending invastigation 6 [ ] Could not be detarmined
28a. Date of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifiar (Check only one): 1 [ ] **Certifying Physician**: To tha bast of my knowladga, death occurrad at tha time, date and place, and dua to tha causa(s) and mannar as stated. 2 [X] **Medical Examiner**: On tha basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifiar: William P. Jones Deputy
29c. License number: D 060 54
29d. Date signed (Month, Day, Year): 5/19/98

30. Nama and address of parson who completed causa of death (Item 23a) (Type, Print): William P. Jones, MD 695 America Ct. 21035

State Registrar

31. Data filed (Month, Day, Year): MAY 22 1998
32. Registrar's Signatura: Gina Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit.

18

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16024

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gloria Glock

2. Data of Death Month: May Day: 19 Year: 1998

3. Time of Death: 0308

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-32-8509

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Oct. 7, 1934

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Streat and Numbar: 7847 Charlesmont Road

10f. Zip Coda: 21222

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Naver Marriad 2☒ Married 3☐ Widowad 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Year or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grada complatad): Elementary/Secondary (0-12): 12 Years; Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Housewife

16b. Kind of Businass/Industry: Own Home

17. Father's Neme (First, Middla, Last): George Brehm

18. Mothar's Nama (First, Middla, Maidan Surnama): Louisa Hilgeman

19a. Informant's Name/Ralationship (Type, Print): Mr. Raymond H. Glock/Husband

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 7847 Charlesmont Road Dundalk, Maryland 21222

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Placa of Disposition (Nama of cametery, crematory or othar place): Hilltop Service Corp. Data: 5/21/1998

20c. Location - City or Town, Steta: Towson, Maryland

21. Signatura of Funaral Sarvica Licansaa: Gregg E. Reed

22. Nama end Addrass of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet causad tha daath. Do not entar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. Entar only ona causa on aach lina.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in daath)

a. Acute Myocardial Infarction — 6 hours

Dua to (or as a consequence of):

Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disaasa or injury that initiated avants resulting in death) Last

b.

Dua to (or as a consaquance of):

c.

Dua to (or as a consaquance of):

d.

Part II. **Othar significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was casa raferrad to medical examiner? 1☐ Yas 2☒ No

26. Placa of Death (Check only ona): Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Homa 5☐ Residence 8☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Spacify)

28f. Location (Streat and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the bast of my knowledga, death occurred at tha time, date and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, date and place, and due to tha cause(s) and mannar statad.

29b. Signatura and titla of certifiar: Suzanne M Cotter MD

29c. Licansa numbar: RES-000

29d. Data signad (Month, Day, Yaar): May 19, 1998

30. Nama and addrass of person who complatad causa of daath (Itam 23a) (Type, Print): Suzanne M Cotter 600 N. Wolfe Street Baltimore, MD 21287

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Data filad (Month, Day, Yaar): MAY 22 1998

32. Registrar's Signatura: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16025

Certificate of Death

Reg. No.

Item#26 per Phy G759 5/22/98 EW

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Martha	Graves		May	8,	1998	2:00 a.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3809 Belle Avenue	Baltimore	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-28-9494	1☐ M 2☒ F	88 Yrs.					May 9 1909	N.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	NA	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
4417 Groveland Ave.	21215	U.S.A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
5th	NA	Inspector	Luggage Co

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thaddeus Noel	Martha Johnson

To Be Completed by Funeral Director

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Eloise Gross- Daughter	4417 Groveland Ave. Balto. md. 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Beechwood Cem.	5-13-98	Roxboro, N.C.

21. Signature of Funeral Servica Licensee	22. Name and Address of Facility
Myron B. Harris	March F.H. West 4300 Wabash Avenue Balto, md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch aa cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarction	1 day
Due to (or as e consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	b. Coronary artery Disease	1 yr
Due to (or as a consequence of):		
	c.	
Due to (or as a consequenca of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings availeble prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify) Group Home

27. Manner of Death	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2☐ **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
M Rel	D 25044	5/8/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M Rehman MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16026

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month	Day	Yaar	3. Tima of Deeth
Raymond Andrew Gallagher	May	15	1998	5:20 A.M.

4a Facility Nama (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington Adventist Hospital	Takoma Park	Montgomery

Funeral Director

5. Social Security Number	6. Sax	7. Aga (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
169 16 0378	X 1☒ M 2☐ F	77 Yrs.			Dec. 4 1920	Pennsylvania

Usual Residance of Dacedant

10a. Stata	10b. County	10c. City, Town or Location	10d. Insida City Limits
Maryland	Prince George's	Bowie	X 1☒ Yas 2☐ No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
2607 Kenway Lane	20715	United States

11. Marital Status	12. Wes Dacedant Ever in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.)	14. Rece - Amaricen Indian, Bleck, Whita, atc.
1☐ Naver Marriad 2☐ Merriad 3☒ Widowad 4☐ Divorcad	1☒ Yes 2☐ No If Yas, Giva Year or Datas: 42-45	1☐ Yas 2☒ No Specify:	Specify: White

15. Dacedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	Maritime Commissioner	United States Government
	1		

17. Fether's Name (First, Middle, Last)	18. Mothar's Nama (First, Middle, Maiden Surname)
Raymond Aloysios Gallagher	Anne Sullivan

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
Roberta Welch Daughter	9102 Grandhaven Ave. Upper Marlboro Maryland 20772

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, Stata
X 1☐ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)	Maryland Veterans Cemetery	May 19, 1998	Crownsville Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Michael L Bigler	Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that ceusad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory errest, shock, or haart feilure. List only one causa on aach lina.

		Approximate Interval Batween Onset and Death
Immediata Causa (Finel disaasa or condition resulting in deeth)	a. Pneumonia	2 weeks
	Due to (or as a consequance of):	
Saquantially list conditions, if any, laading to immadiata ceusa. Entar Underlying Causa (Disaasa or Injury thet initiated events resulting in death) Last	b.	
	Due to (or as a consequance of):	
	c.	
	Dua to (or as a consequance of):	
	d.	

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying ceusa givan in Part I.

Alcoholism

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?	24a. Wes an autopsy performed?	24b. Ware autopsy findings available prior to completion of causa of daath?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yas 2☒ No	1☐ Yas 2☒ No

25. Was cesa ratarred to medical exeminar?	26. Placa of Death (Check only one)	
1☐ Yas 2☒ No	Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not ba determined		M	1☐ Yes 2☐ No	
	28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify)			28t. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To tha bast of my knowledge, deeth occurred at the tima, data and place, and dua to tha cause(s) and manner as stetad.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and manner stated.

29b. Signatura and title of certifier	29c. Licansa number	29d. Data signed (Month, Day, Year)
▶ [signature]	D-36601	5-16-1998

30. Nama and address of person who completed ceusa of death (Item 23a) (Type, Print)
DAVID M. BRILL 7600 CARROLL AVE. TAKOMA PARK MD 20912

State Registrar

31. Data filad (Month, Day, Year)	32. Registrar's Signature
MAY 22 1998	▶ Julia Davidson-Randall

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16027

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John D. Greenhalgh
2. Date of Death Month: 5 Day: 13 Year: 98
3. Time of Death: 1859
4a. Facility Name *(If not institution, give street and number)*: University of Maryland Emergency
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: City

Funeral Director

5. Social Security Number: 578-34-8218
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 68 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 1/ 11 /1930
9. Birthplace *(State or Foreign Country)*: PA.

Usual Residence of Decedent

10a. State: VA.
10b. County: Fairfax co.
10c. City, Town or Location: McLean
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1350 Beverly Rd. Apt. 311
10f. Zip Code: 22101
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1950-1953
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): +4
18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Engineer
16b. Kind of Business/Industry: Federal Govt.

17. Father's Name *(First, Middle, Last)*: Arthur Greenhalgh
18. Mother's Name *(First, Middle, Maiden Surname)*: Helen Daingerfield

19a. Informant's Name/Relationship *(Type, Print)*: Nancy Greenhalgh (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1350 Beverly Rd. Apt.311, McLean, VA. 22101

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cremation Center
Date: 5/17/98
20c. Location - City or Town, State: Chantilly, VA.

21. Signature of Funeral Service Licensee: Joseph Charlton
22. Name and Address of Facility: Murphy Falls Church Funeral Home, 1102 W. Broad St., Falls Church, VA. 22046

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Asystole
Due to (or as a consequence of):
b. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: DePriest W. Wyatt
29c. License number: D33913
29d. Date signed *(Month, Day, Year)*: 5/13/98
30. Name and address of person who completed cause of death (Item 28a) *(Type, Print)*: DePriest W. White Jr 22 S. Greene St, Baltimore, MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1998
32. Registrar's Signature: Jutta Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

18

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16028

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIE GILL JR.

2. Date of Death (Month, Day, Year): MAY 17, 1998

3. Time of Death: 5:15 AM

4a. Facility Name (If not institution, give street and number): 4530 CLAREWAY (HOME)

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 240-34-6019

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV 27, 1929

9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10e. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 4530 CLAREWAY

10f. Zip Code: 21213

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 46-47

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: AFRO. AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7

College (1-4or 5+): 0

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LINEMAN

16b. Kind of Business/Industry: B.G.&E

17. Father's Name (First, Middle, Last): WILLIE GILL SR.

18. Mother's Name (First, Middle, Maiden Surname): MINERVA DUNN

19e. Informant's Name/Relationship (Type, Print): SHIRLEY GILL

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4530 CLAREWAY, BALTIMORE, MARYLAND 21213

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST CEM.

Date: 5/21/98

20c. Location - City or Town, State: OWINGS MILL, MD.

21. Signature of Funeral Service Licensee: Carl A Estep

22. Name and Address of Facility: ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. COPD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Metastatic prostate cancer

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cachexia
Chronic foley catheter
prostate enlargement causing bladder obstruction

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: C Gilman M.D

29c. License number: D0051156

29d. Date signed (Month, Day, Year): 5/20/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): D.A. CADAN, M.D. BEACHAM GERIATRICS Center, BALTIMORE, 21224

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16029

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY LUCILLE HEFNER

2. Date of Death (Month, Day, Year): May 21 1998

3. Time of Death: 0355

4a. Facility Name *(If not institution, give street and number)*: Genesis Eldercare Hammonds Lane Center

4b. City, Town, or Location of Death: Brooklyn Park

4c. County of Death: Anne Arundel County

Funeral Director

5. Social Security Number: 242-14-0384

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 12, 1920

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 115 Camrose Avenue

10f. Zip Code: 21225-3609

10g. Citizen of Whet Country?: United States

11. Meritet Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6; College (1-4or 5+): 0

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Line Helper-Saniter

16b. Kind of Businass/Industry: Calverts Distillery

17. Fether's Neme *(First, Middle, Last)*: Roby Teague

18. Mother's Name *(First, Middle, Maiden Surneme)*: Hattie Mae Taunt

19a. Informant's Name/Reletionship *(Type, Print)*: Judy Wingate-Morning/daughter

19b. Meiling Addrass *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 115 Camrose Avenue Baltimore, Maryland 21225-3609

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Pleca of Disposition *(Neme of cemetery, cremetory or other pleca)*: Cedar Hill Cemetery

Dete: May 23, 1998

20c. Location - City or Town, State: Baltimore, Maryland

21. Signeture of Funerel Service Licensee: Alan C. Dunn

22. Neme end Address of Fecility: McCully-Polyniak Funeral Home 237 East Patapsco Avenue Baltimore MD 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not anter tha mode of dying, such es cardiec or respiretory errast, shock, or haert failura. List only ona ceuse on eech line.

Approximata Intarval Batween Onset and Deeth

Immediate Ceuse (Finel disaasa or condition resulting in deeth)

a. Pneumon.

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leeding to immediete causa. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Last

b. Congestive Heart Failure

Due to (or es e consequanca of):

c.

Due to (or es e consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Copy by Diseo

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes casa rafarred to medical exeminar? 1☐ Yes 2☒ No

26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Daath: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, data end pleca, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On tha basis of examination end/or investigetion, in my opinion, daeth occurred et the time, dete end pleca, and due to the cause(s) end manner stated.

29b. Signeture end title of certifier: John.

29c. License number: D 45249

29d. Date signed (Month, Day, Year): 5/21/98

30. Neme end eddress of person who completed causa of daath (Item 23a) (Type, Print): 1600 S Crain Hy Suite 201 Glen Burnie MD 21061 Dr. Sharma, Susheel

State Registrar

31. Data filed *(Month, Dey, Year)*: MAY 22 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16030

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
John R. Heizmann	May 20, 1998	10:00 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Carroll County General Hospital	Westminster	Carroll

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
381-01-0636	1[X] M 2[ ] F	83 Yrs.			11-13-1914	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Phoenix	1[ ] Yes 2[X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13714 Killarney Court	21131	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[ ] Married 3[X] Widowed 4[ ] Divorced	1[X] Yes 2[ ] No If Yes, Give Year or Dates: WWII	1[ ] Yes 2[X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Industrial Engineer	Dept. Of The Navy

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
F. Edward Heizmann	May K. Kauffman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs Mary Elizabeth Mansperger (Daughter)	13714 Killarney Court, Phoenix, Md. 21131

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	Gethsemane Cemetery	5-26-98	Laureldale, Pa.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Wallace S. Ruck, Jr.	Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarction	Two hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[✓] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[✓] No	1[ ] Yes 2[✓] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1[ ] Yes 2[✓] No	Hospital: 1[ ] Inpatient 2[✓] ER/Outpatient 3[ ] DOA	Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[✓] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending Investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1[✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.
2[ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and pleca, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
▶ MD	D33184	May 21, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jonathan Kushner 114 Business Center Drive Reisterstown, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 1998	▶ Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16031

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDGAR HUGHES

2. Date of Death: Month: May; Day: 19; Year: 1998

3. Time of Death: 5:00 A.M.

4a. Facility Name (If not institution, give street and number): Genesis Elder Care

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Balto

Funeral Director

5. Social Security Number: 219-10-4897

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 8-29-1907

9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: Md

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 3810 Patterson Avenue

10f. Zip Code: 21207

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6th grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): laborer

16b. Kind of Business/Industry: Bethlehem Steel

17. Father's Name (First, Middle, Last): Haywood Hughes

18. Mother's Name (First, Middle, Maiden Surname): Mary Jane Brooks

19a. Informant's Name/Relationship (Type, Print): Shirley T. Hughes-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7916 Dunhill Village Apt 302 Randallstown, Md 21244

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Memorial Park

Date: 5-23-98

20c. Location - City or Town, State: Arbutus, Md

21. Signeture of Funeral Service Licensee: Lola March

22. Name and Address of Facility: March F.H. West 4300 Wabash Avenue Balto, Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. VENTRICULAR fibrillation

Due to (or as a consequence of): b. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

Due to (or es e consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: COPD. High Blood Pressure

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stella Diamond

29c. License number: D 15300

29d. Date signed (Month, Day, Year): 5-20-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stella Diamond 6809 Registertown Rd Balto Md 21215

State Registrar

31. Date filed (Month, Day, Year): MAY 28 1998

32. Registrar's Signature: Sharon Hudson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as a burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16032

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Lest): MORRIS HOFFMAN
2. Dete of Deeth: Month MAY Dey 16 Year 1998
3. Time of Deeth: 7:30 pm
4e. Feclity Name (If not institution, give street end number): GOOD SAMARITAN HOSP.
4b. City, Town, or Location of Deeth: BALTIMORE
4c. County of Deeth: N/A

Funeral Director

5. Socie! Security Number: 217-03-5215
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. lest birthdey): 93 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): NOV. 1, 1904
9. Birthplece (Stete or Foreign Country): MD.

Usuel Residence of Decedent

10a. Stete: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10a. Street and Number: 6116 BELAIR RD.
10f. Zip Code: 21206
10g. Citizen of Whet Country?: U.S.A.
11. Maritel Stetus: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - Americen Indien, Bleck, White, etc. Specify: WHITE
15. Decedent's Educetion (Specify only highest grede completed) — Elementery/Secondary (0-12): UNKNOWN; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): UNKNOWN
16b. Kind of Business/Industry: UNKNOWN
17. Fether's Neme (First, Middle, Lest): UNKNOWN
18. Mother's Neme (First, Middle, Maiden Surneme): UNKNOWN
19e. Informent's Neme/Relationship (Type or Print): WANDA COM. ON AGING. BIACKWELL
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 1000 CATHEDRAL ST. BALTO. MD. 21201
20e. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): VOSHELLS CEM.
Dete: MAY 23 1997
20c. Locetion - City or Town, Stete: BALTO. MD.
21. Signeture of Funerel Service Licensee: Thomas J. Skalda Jr.
22. Neme end Address of Fecility: SKALDA F.H. 2829 HUDSON ST BALTO., MD. 21224

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory erfest, shock, or heert feilure. List only one ceuse on eech line.

		Approximete Intervel Between Onset end Death
Immediete Ceuse (Finel diseese or condition resulting in deeth) e.	PNEUMONIA.	10 days
Due to (or es e consequence of):		
Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest b.	CHF	7 1 year
Due to (or es e consequence of):		
c.	APLASTIC ANEMIA	7 1 month
Due to (or es e consequence of):		
d.	ATRIAL FIBRILLATION	7 1 month

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying ceuse given in Pert I.: PROSTATE CANCER

23b. **Did tobecco use contribute to the cause of deeth?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings evelleble prior to completion of ceuse of deeth? 1 [ ] Yes 2 [X] No

25. Was cese referred to medicel exeminer? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one) — Hospitel: 1 [X] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28e. Dete of Injury (Month, Dey Yeer):
28b. Time of Injury: M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred:
28e. Ptece of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Locetion (Street and Number or Rurel Route Number, City or Town, Stete):

29e. Certifier (Check only one) 1 [X] **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted. 2 [ ] **Medicel Exeminer:** On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: [signature] MD
29c. License number: P-11389
29d. Dete signed (Month, Dey, Yeer): MAY 16, 1998

30. Neme end edress of person who completed ceuse of deeth (Item 23a) (Type, Print): GILBERT ZOGHBI 6935 DONACHIE Rd APT 6 BALTIMORE MD 21239.

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 22 1998
32. Registrer's Signeture: Julie Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 9058.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16033

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elizabeth Shepperd Hohman
2. Date of Death Month / Day / Year: May 17, 1998
3. Time of Death: 11:15PM
4a. Facility Name *(If not institution, give street and number)*: 7304 Longfield Drive
4b. City, Town, or Location of Death: Kingsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-74-6406
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 95 Yrs. — If Under 1 Yaer: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: July 31,1902
9. Birthpleca *(State or Foraign Country)*: Baltimore City,Md.

Usual Residanca of Decedent

10a. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Kingsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7300 Longfield Drive
10f. Zip Coda: 21087
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forcas? 1☐ Yes 2☒ No — If Yas, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Raca - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondery (0-12): 8 yrs. — College (1-4or 5+): n/a
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Business Manager
16b. Kind of Business/Industry: Kingsville Nursery

17. Father's Neme *(First, Middla, Last)*: Francis Graydon Shepperd
18. Mother's Name *(First, Middle, Maidan Surneme)*: Mary Bradley

19a. Informant's Neme/Relationship *(Type, Print)*: Mrs. Mary H. Quinlan (Daughter)
19b. Melling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 518 Yarmouth Road Towson,Maryland 21286

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Othar *(Specify)*
20b. Pleca of Disposition *(Neme of cemetery, cremetory or other plece)*: St.Stephens Church Cem.
Date: 5/21/98
20c. Location - City or Town, State: Bradshaw,Md.21021

21. Signeture of Funerel Service Licensee: Heather Lassahn Chojnacki
22. Name end Address of Facility: E.F. Lassahn Funeral Home, P.A. 11750 Belair Road Kingsville, Maryland 21087-1351

Physician /Medical Examiner

23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only ona causa on aach lina.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in deeth)
e. MESENTERIC INFARCTION — 12 h.

Dua to (or as a consequanca of):
b. ASCVD — 24.

Sequentially list conditions, if eny, leeding to immediete causa. Entar Underlying Ceuse (Disaase or Injury that initiated events resulting in death) Lest
Due to (or es a consequence of):
c. HYPERTENSION — 20y.

Due to (or es e consequenca of):
d.

Part II. **Other signifficant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributa to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveliable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Othar *(Specify)*

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be detarmined

28a. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Descirbe how Injury occurred
28e. Pleca of Injury - At homa, farm, straet, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, deta end pleca, and due to tha causa(s) and mannar as stated.
2☐ **Medical Examiner:** On tha basis of examinetion end/or investigation, in my opinion, daath occurred at tha tima, data end placa, and dua to the cause(s) end menner steted.

29b. Signature and title of certifier: Jon F Lounlad
29c. License number: D-12990
29d. Date signed *(Month, Dey, Year)*: 5/18/98

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): 7801 YORK RD TOWSON, MD. 21204

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 2 2 1998
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Elizabeth Hohman
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

15

98 16034

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ruth Elizabeth Jaeger			2. DATE OF DEATH (Month, Day, Year): 5 17 98	3. TIME OF DEATH: 4 25 P M
4. SOCIAL SECURITY NUMBER: 216-34-9122	5. SEX: 1 ☐ M XX F	6. AGE (In yrs. last birthday): 100 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov. 18, 1897	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Alice Manor Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? XX 1 YES 2 ☐ NO
10e. STREET AND NUMBER: 1012 N. Bentalou Street		10f. ZIP CODE: 21216		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: XX 1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES XX NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. OECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): Ø		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Henry Jaeger			18. MOTHER'S NAME (First, Middle, Maiden Surname): Henrietta Weber	
19a. INFORMANT'S NAME (Type/Print): Thomas R. a'Becket/Gr Nephew		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 510 Bramblewood Court, Millersville, MD 21108		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Washington Cr.	DATE: 5/19	20c. LOCATION — City or Town, State: Laurel, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Steven Hollman		22. NAME AND ADDRESS OF FACILITY: Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, MD 20707		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Pulmonary Embolism — Minutes

DUE TO (OR AS A CONSEQUENCE OF): b. Chronic Phlebitis

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Breast Cancer

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert D Diamond MD	29c. LICENSE NUMBER: D23076	29d. DATE SIGNED (Month, Day, Year): ▶ 5-17-98
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RICH ARD C DIAMOND 3730 Falls Rd Balt Md 21211		
31. DATE FILED (Month, Day, Year): MAY 22 1998	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

98-2775-510
B.K.S
JEFFREY JOHNSON

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16035

Items: 23 part I,27,28a-f per MEO G-759 5/28/98 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Jeffrey T. Johnson	MAY 16, 1998	1638 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3110 WEST GARRISON AVENUE	BALTIMORE	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-64-2188	1☒ M 2☐ F	41 Yrs.			August 31, 1956	Md

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	N/A	Baltimore	1☒ Yes 2☐ No XX

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5514 Haddon Avenue	21207	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th grade	N/A	Janitor	Cleaners

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Johnson II	Mary Wilson

19a. Informent's Neme/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
Gwendolyn Kugenga - Sister	5514 Haddon Avenue Apt 2 B Baltimore, Md 21207

20a. Method of Disposition	20b. Piace of Disposition (Neme of cemetery, crematory or other piace)	Date	20c. Location - City or Town, State
1☒ Buriat 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Voshell Memorial	5-22-98	Baltimore, Md

21. Signeture of Funeral Service Licensee	22. Name and Address of Feciility
▶ Lola March	March F/H West 4300 Wabash Avenue Baltimore, Md 21215

Physician /Medical Examiner

23a. Pert. Enter the disease, or complications that caused the daath. Do not antar tha moda ot dying, such as cerdiac or raspiratory arrast, shock, or heart failure. List only ona causa on aach tina.

Approximata Intarval Batween Onset end Deeth

Immediate Cause (Final diseese or condition resulting in daeth)
e. NARCOTIC AND COCAINE INTOXICATION

Dua to (or es a consequance ot):

Sequentiellly list conditions, if any, leeding to immedieta ceuse. Enter Undarlying Cause (Disaese or injury thet initieted events rasulting in death) Lest
b.
Due to (or es e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed?	24b. Were eutopsy findings availebie prior to completion of ceuse of daath?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was cesa referrad to medical examiner?	26. Piece of Deeth (Check only ona)	
1☒ Yas 2☐ No	Hospitet: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA	Othar: 4☐ Nursing Home 5☐ Residance 6☒ Other (Specify) AT SCENE

27. Mennar of Deeth	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined	Unknown	Unknown M	1☐ Yes 2☒ No	Unknown

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, State)
Unknown	Unknown

29a. Certifiar (Check only one)
1☐ **Certifying Phyeician:** To tha best of my knowiedga, daath occurred at tha tima, date and piece, end dua to the ceuse(s) and menner as stated.
2☒ **Medical Examiner:** On the besis of exemination and/or investigation, in my opinion, death occurred et the time, dete end place, end due to the causa(s) and mennar steted.

29b. Signature and titie of certifier	29c. License number	29d. Dete signed (Month, Dey, Year)
▶ Stephen S. Radentz MD	O.C.M.E	MAY 17, 1998

30. Name and eddress of person who completed ceuse of daath (Item 23a) (Type, Print)
Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Yaar)	32. Registrar's Signature
MAY 22 1998	▶

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DENISE JOHNSON

2. Date of Death: Month: May Day: 20 Year: 1998

3. Time of Death: 4:35 AM

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-86-6527

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 34 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 8-25-63

9. Birthplace (State or Foreign Country): MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md

10b. County: N/A

10c. City, Town or Location: BALTimore

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 908 KEVIN ROAD

10f. Zip Code: 21229

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): UNEMployed

16b. Kind of Business/Industry: UN KNOWN

17. Father's Name (First, Middle, Last): DENNIS HARRELL

18. Mother's Name (First, Middle, Maiden Surname): ELAINE JOHNSON

19a. Informant's Name/Relationship (Type, Print): ELAINE THOMAS - MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1435 PATTERSON PARK AVE. BALTO. MD. 21213

20a. Method of Disposition: 1☐ Burial 2☑ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): METRO. CREMATORY

Date: 5/22/98

20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: Jeff Miller

22. Name and Address of Facility: 1639 N. BROADWAY BALTO. MD. 21213 JEFF MILLER P.A. FUNERAL HOME & SERVICE

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis

Due to (or as a consequence of):

b. Human Immunodeficiency Virus

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Intravenous Drug Abuse

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Shirley Nattakorn

29c. License number: 89314

29d. Date signed (Month, Day, Year): 5/20/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Shirley Nattakorn, M.D. C/O Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Re: Denise Johnson

98-2777-510
B.K.S
ALLEN JONES

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16037

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
ALAN E. JONES	MAY 16, 1998	2044 PM

4e Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1200 BLK. NORTH DALLAS STREET	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-76-1203	1 [X] M 2 [ ] F	36 Yrs.			DEC. 5, 1961	Md

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	N/A	BALTIMORE CITY	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
410 W. FRANKLIN STREET	21201	U.S.A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: NEGRO

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 th		COOK	RESTAURANT

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
WILLIAM JONES	SHIRLEY JEFFERSON

19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SHIRLEY JONES/MOTHER	410 W. FRANKLIN ST. BALTO.,Md 21201

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
[X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	VOSHELL MEM. GARDEN	MAY 23,	1998 BALTO.,Md

21. Signature of Funeral Service Licensee: Calvin B. Scruggs, Sr.

22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO., Md 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Stab wound of Chest	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [X] Yes 2 [ ] No	1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [X] Yes 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) AT SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	5-16-98	2034 M	1 [ ] Yes 2 [X] No	Subject stabbed
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Steps			28f. Location (Street and Number or Rural Route Number, City or Town, State) 2200 Block N. Dallas Baltimore City, Maryland

29e. Certifier (Check only one)
1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Stephen S. Radentz, MD	O.C.M.E	MAY 17, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16038

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)	3. Time of Death
Donald	Foulke	Kanzler	May 21 1998	11:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
30 Haddington Rd.	Lutherville	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218 22 7937	1 [X] M 2 [ ] F	71 Yrs.			April 29, 1927	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Lutherville	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
30 Haddington Rd.	21093	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	[X] Yes 2 [ ] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	2	Self Employed	Manufacturing Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Anton Samuel Kanzler	Myrtle Foulke

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Alice N. Kanzler / Wife	30 Haddington Rd., Lutherville, MD 21093

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Green Mount Crematory	5/22/98	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Stephen D Lohrmann	CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARDIOPULMONARY ARREST	6 mins.
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. METASTATIC ADENOCARCINOMA OF LUNG	2 yrs.
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Lawrence J. Scharf, M.D.	D43173	5/22/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAWRENCE J. SCHARF, M.D. 7605 OSLER DR. TOWSON, MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 1998	▶ Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16039

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert R. Kumm

2. Date of Death Month / Day / Year: May 18 1998

3. Time of Death: 6:15 P.M.

4a. Facility Name *(If not institution, give street and number)*: 6828 Glenwood Court

4b. City, Town, or Location of Death: Glenn Dale

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579 26 3189

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 4 1926

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Goerge's

10c. City, Town or Location: Glenn Dale

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6828 Glenwood Court

10f. Zip Code: 20769

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Nevar Marriad 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☒ Yas 2☐ No
If Yas, Giva Yaar or Datas: WWII

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Ricen, atc.)
1☐ Yas 2☒ No *Specify:*

14. Race - Amaricen Indian, Black, White, atc.
Specify: White

15. Decedant's Education *(Specify only highast grada completed)*
Elementery/Secondery (0-12): 12
Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Computer Analyst

16b. Kind of Businass/Industry: U.S. Government

17. Fathar's Nema *(First, Middla, Last)*: Henry Kumm

18. Mothar's Nema *(First, Middla, Maidan Surname)*: Kathrine Seiler

19a. Informant's Name/Relationship *(Type, Print)*: Mavis M. Kumm Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6828 Glenwood Court Glenn Dale Maryland 20769

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramovel from State 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cemetery, cramatory or othar place)*: Maryland Veterans Cemetery Date: May 21, 1998

20c. Location - City or Town, State: Cheltenham Maryland

21. Signature of Funaral Sarvica Licensee: ▶ Michael J Bijlani

22. Nama and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused the death. Do not antar the moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on each line.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in death)
a. Metastatic Prostate Cancer — 9 mo.

Dua to (or as a consequance of):

Saquantially list conditions, if any, laading to immediata ceuse. Entar Underlying Causa (Disease or Injury thet initiated evants resulting in daath) Lest
b.

Dua to (or es a consequance of):
c.

Dua to (or as a consequance of):
d.

Part II. **Other aignificant conditions** contributing to death but not resulting in tha underlying ceusa givan in Part I.
Coronary Artery disease, congestive heart failure, Anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopay performed? 1☐ Yes 2☑ No

24b. Wara autopsy findings availabla prior to complation of cause of daath? 1☐ Yes 2☐ No

25. Was cese refarred to madical axaminer? 1☐ Yaa 2☑ No

26. Place of Death *(Check only one)*
Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Homa 5☑ Residance 6☐ Othar *(Specify)*

27. Manner of Daath: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigetion 6☐ Could not ba datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At homa, farm, streat, fectory, offica building, atc. *(Specify)*

28f. Location *(Streat and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*
1☑ **Certifying Physician**: To the best of my knowladga, daath occurred at the tima, data and piace, and dua to tha causa(s) and mannar as stated.
2☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete end piece, end dua to tha cause(s) and manner stated.

29b. Signatura and titla of certifiar: ▶ Tara T Muscovich MD

29c. Licansa number: D46942

29d. Date signed *(Month, Day, Year)*: 5/19/98

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): Tara T. Muscovich MD 14300 Gallant Fox La, Suite 118 Bowie, MD 20715

State Registrar

31. Data filed *(Month, Day, Yaar)*: MAY 22 1998

32. Ragistrar's Signatura: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16040

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NELLIE . A. KING

2. Date of Death Month: MAY Day: 19 Year: 1998

3. Time of Death: 10:45 AM

4a. Facility Name (If not institution, give street and number): 2710 FLEETWOOD. AVE.

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-22-4882

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MARCH 27, 1923

9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTO. CITY

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street end Number: 2710 FLEETWOOD AVE

10f. Zip Code: 21214

10g. Citizen of Whet Country? U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Wes Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DIETARY

16b. Kind of Business/Industry: HOSPITAL

17. Father's Name (First, Middle, Last): SAM PETTY

18. Mother's Name (First, Middle, Maiden Surname): NELLIE . A. FLESHMAN

19a. Informant's Name/Relationship (Type, Print): KENNETH . A. KING

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2710 FLEETWOOD. AVE. BALTO. MD 21214

20a. Method of Disposition: 1☐ Burial 2☑ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Cemetery

Date: 5/21/98

20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: Hartley Miller

22. Name and Address of Facility: HARTLEY Miller Funeral Home 7527 HARFORD RD BALTO. MD 21234

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardio-Pulmonary arrest — 1day

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Post operatior thyroid surgery — 1 month

Due to (or as a consequence of):

c.

Due fo (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical exeminer? 1☐ Yes 2☑ No

26. Place of Death (Check only one) Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, end due to the cause(s) end manner steted.

29b. Signature end title of certifier: Glenn

29c. License number: D 7040

29d. Date signed (Month, Day, Year): 5/21/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAHASCHAI MUSIC ADAMMA 1910 - W. Pratt ST. BALTO MD 21223

State Registrar

31. Date filed (Month, Day, Year): MAY 2 2 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16041

John LENZI

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Paul Lenzi

2. Date of Death: Month May Day 20 Year 1998

3. Time of Death: 9:36 Pm

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 031-01-2549

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 19, 1917

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10a. Street and Number: 1505 Becklow Avenue

10f. Zip Code: 21220

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steam Fitter

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Joseph Lenzi

18. Mother's Name (First, Middle, Maiden Surname): Teresa Giordano

19a. Informant's Name/Relationship (Type, Print): Margaret Grose (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 116 West Francis Street Ise Lin, N.J. 08830

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Crematory

Date: 5/26/1998

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: John W. Burkowske

22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Squamous Cell Lung Cancer — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: RD 187153

29d. Date signed (Month, Day, Year): 5/21/91

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR Carolyn Tabak 9000 Franklin Square Drive Baltimore MD 21237

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998

32. Registrar's Signature: Erika Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10x1

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 19a per F.H. G-759 5/27/98 reb

Certificate of Death

Reg. No. 98 16042

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THOMAS G. LAWSON
2. Date of Death Month: MAY Day: 20 Year: 1998
3. Time of Death: 8:00 pm
4a. Facility Name (If not institution, give street and number): Joseph Richey House
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

Funeral Director

5. Social Security Number: 218-36-4431
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 58 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11 27 39
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 6810 PARK Heights AVE
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12TH GRADE
College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): GENERAL OFFICE CLERK
16b. Kind of Business/Industry: ARMY

17. Father's Name (First, Middle, Last): WILLIAM CHESSON
18. Mother's Name (First, Middle, Maiden Surname): PALMETTO LAWSON

19a. Informant's Name/Relationship (Type, Print): TONY LAWSON - ~~SON~~ BROTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215: 3303 W. NORTHERN PKWY. BALTO MD

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST VA
Date: 5-26-98
20c. Location - City or Town, State: OWING MILLS MD

21. Signature of Funeral Service Licensee: ▶ Gabrielle Cook
22. Name and Address of Facility: WM. C MARCH FUNERAL HOME WEST INC 4300 WABASH AVE, BALTO MD 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CARCINOMA LUNG. — 5 yrs.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part ii. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☑ Other (Specify) Hospice

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day Year)
28b. Time of injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated.

29b. Signature and title of certifier: ▶ Robert C. Irwin MD
29c. License number: D058900
29d. Date signed (Month, Day, Year): 5-21-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert C. Irwin MD 838 N. Gilmor St. Balto Md 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998
32. Registrar's Signature: ▶ Gina Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be completed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16043

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNA LINK
2. Deta of Deeth (Month, Day, Yeer): MAY 17, 1998
3. Time of Death: 1:48 pm
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: A.A. COUNTY

Funeral Director

5. Social Security Number: 180 22 0420
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 70 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): March 16, 1928
9. Birthplece (State or Foreign Country): Pennsylvania

Usuel Residence of Decedent

10e. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Bowie
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street and Number: 15018 Newcomb Lane
10f. Zip Code: 20716
10g. Citizen of Whet Country?: United States

11. Merital Stetus: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Fether's Name (First, Middle, Last): Thomas Ward
18. Mother's Neme (First, Middle, Maiden Surname): Unavailable

19e. Informent's Name/Reletionship (Type, Print): Charles Link Son
19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15018 Newcomb Lane Bowie Maryland 20716

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
Date: May 20 1998
20c. Location - City or Town, Stete: Brentwood Maryland

21. Signeture of Funeral Service Licensee: Michael L Bejlo
22. Name end Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Road Bowie Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset end Deeth

immediate Ceuse (Finel diseese or condition resulting in deeth): e. Pleural Effusion - possibly malignant — 4 days
Due to (or as e consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: GI Bleeding

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings availeble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medicai exeminer? 1☐ Yes 2☑ No
26. Piece of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) and manner es stated. 2☐ **Medical Examiner**: On the basis of exemination and/or investigetion, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) end menner steted.

29b. Signetura end title of certifier: MD
29c. Licensa number: D43977
29d. Data signed (Month, Day, Year): May 17 1998

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): Oyyken Okeinnji. 301 Hospital Drive, Glen Burnie, MD. 21061.

State Registrar

31. Dete filed (Month, Day, Year): MAY 22 1998
32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16044

LEWIS, INDIA

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
INDIA	LEWIS		MAY 20, 1998	12:15 PM
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death	4c. County of Death	
FRANKLIN SQUARE HOSPITAL CENTER		ROSEDALE	BALTIMORE	

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
308-14-5602	1☐ M 2☑ F	91 Yrs.			9-6-1907	unk

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	BALTIMORE	1☑ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6116 Belair Rd	21206	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced	1☐ Yes 2☑ No If Yes, Give Year or Dates:	1☐ Yes 2☑ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
unk	unk	unk	unk

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
unk	unk

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Wanda Blackwell guardian	1000 CATHedral St. BALTIMORE, MD 21201

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	MT ZION CEMETERY	5/21/98	Lansdowne, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Albert P. Wylie F/H PA 638 N. Gilmor St. Balto. MD. 21217

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Pneumonia	5 days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Multi Infarct Dementia	5 days
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Stuart R. Willes MD	D36663	05/20/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR STUART WILLES MD 9000 FRANKLIN SQUARE DR BALTO MD 21237

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16045

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Ruth M. Lewis
2. Dete of Deeth: Month 5 Day 11 Year 98
3. Time of Deeth: 3:40 P.M.
4e. Fecility Neme (If not institution, give street and number): Liberty Medical Center
4b. City, Town, or Location of Deeth: Baltimore
4c. County of Death:

Funeral Director

5. Sociel Security Number: 213-26-3061
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Yeer: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): 12 17 22
9. Birthpleca (State or Foreign Country): Maryland

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street end Number: 2095 Rockrose Avenue
10f. Zip Code: 21211
10g. Citizen of Whet Country? U.S.
11. Meritel Stetus: 1 ☐ Never Merried 2 ☐ Married 3 X Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - Americen Indien, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 9th; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Homemaker
17. Fether's Neme (First, Middle, Last): Marshall Holsey
18. Mother's Neme (First, Middle, Maiden Sumeme): UNKNOWN
19a. Informent's Neme/Reletionship (Type, Print): Sadie Matthews sister in law
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 448 Oxford Count Baltimore, Maryland 21217
20e. Method of Disposition: 1 X Burlel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Placa of Disposition (Neme of cemetery, cremetory or other piece): MT. Zion
Dete: 5-20-98
20c. Location - City or Town, Stete: Baltimore, Maryland
21. Signeture of Funerel Service Licensee: Irvin P. Carroll
22. Neme end Address of Facility: Irvin P. Carroll Funeral Home 1712 W. North Avenue Baltimore, Maryland

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Deeth

Immedlete Ceuse (Finel diseese or condition resulting in deeth)
e. Respiratory FAILURE with
Due to (or es e consequence of):
b. ADULT RESPIRATORY Distress Syndrome
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last
Due to (or es e consequenca of):
c. Cartinoma of colon with metastasis
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco uss contribute to the causs of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 X Unknown

24e. Wes an eutopsy performed? 1 ☐ Yes 2 X No

24b. Were eutopsy findings eveileble prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 X No

26. Plece of Deeth (Check only one): Hospitel: 1 X Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Deeth: 1 X Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) and manner es stated. 2 ☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end menner steted.

29b. Signeture end litle of certifier: R.M. Shah M.D.

29c. License number: D19668

29d. Dete signed (Month, Dey, Yeer): MAY 11, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): R.M. SHAH M.D., LMC. 2600 LIBERTY HT AVE. Baltimore MD

State Registrar

31. Date filed (Month, Dey, Yeer): MAY 22 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16046

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
JAMES	IRVIN	LOCKARD	MAY	20	1998	6:55 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
GENESIS ELDERCARE LONGGREEN	BALTIMORE CITY	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-18-6822	1 [X] M 2 [ ] F	77 Yrs.					5/4/21	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE CITY	[X] 1 Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2013 W. BALTIMORE STREET	21223	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	[X] 1 Yes 2 [ ] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11th GRADE		MACHINIST	KOPPERS

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
HOWARD I. LOCKARD	EDNA ROGERS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARY BIRKMAIER SISTER	2 MUIRFIELD COURT LUTHERVILLE, MD 21093

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	METRO CREMATORY, INC.	5/21/98	CATONSVILLE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Heather N. Hayes	JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ASHD with Silent MI	Minutes
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD
Seizure Disorder
Schizophrenia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	N/A 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D17118	5/21/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Paul Schwartz M.D. 4000 Old Court Rd #203 21208

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 1998	Lisa Davidson-Randall

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

4X1

DHMH 16 Rev 6/95

98-2627-510
DDG
JAQUANNDRE LEONARD

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I,27 per MEO G-760 6/10/98 rev

Certificate of Death

Reg. No. 98 16047

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JAQUANNDRE DASHAWN LEONARD	MAY 7, 1998	0532 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MARYLAND GENERAL HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
NONE	1☒ M 2☐ F	0 Yrs.	0	0	3	15	MAY 7,1998	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3917 RIDGECROFT ROAD	21206	U.S.A.

11. Marital Status	12. Was Decedent Ever In U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: AFR. AMERICAN

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
0	0	N/A	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JAMES SMITH	BENITA McFARLAND

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BENITA McFARLAND (MOTHER)	3917 RIDGECROFT RD BALTO. MD 21206

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	METRO CREMATORY	MAY 19,1998	CATONSVILLE MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
EUGENE N WALKER	ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. COMPLICATIONS OF DELIVERY	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J. LARON LOCKE, MD	O.C.M.E.	MAY 9, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16048

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robertine Margarette Morley
2. Date of Death (Month, Day, Year): May 18, 1998
3. Time of Death: 12:00 pm
4a. Facility Name (If not institution, give street and number): 323 Riverside Drive
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214 38 3872
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 3, 1909
9. Birthplace (State or Foreign Country): Indiana

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 323 Riverside Drive
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Teacher
16b. Kind of Business/Industry: Elementary School

17. Father's Name (First, Middle, Last): Thomas McNeel
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Keasling

19a. Informant's Name/Relationship (Type, Print): William Morley (husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 323 Riverside Drive Essex, Maryland 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith
Date: May 21, 1998
20c. Location - City or Town, State: Baltimore County, Md

21. Signature of Funeral Service Licensee: James Bruzdzinski
22. Name and Address of Facility: Bruzdzinski Funeral Home PA
1407 Old Eastern Avenue Essex, Maryland 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. sepsis and dehydration — 3days
Due to (or as a consequence of): b. small bowel obstruction — about 1 wk
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: c. adhesions
Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: end-stage Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Arthur F. Schroeder MD
29c. License number: D-26434
29d. Date signed (Month, Day, Year): 5/19/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ARTHUR F. SCHROEDER MD MIDDLESEX HEALTH CENTER 1245 EASTERN BLVD. BALTIMORE MD 21221

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998
32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16049

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DANIEL W. MADISON
2. Date of Death: Month MAY Day 19 Year 1998
3. Time of Death: 4.30AM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-07-4355
6. Sex: 1 X M 2 F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 13, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore County
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 Yes 2 X No
10e. Street and Number: 2045 Putnam Road
10f. Zip Code: 21227
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 Never Married 2 Married 3 X Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Glass Worker
16b. Kind of Business/Industry: Carlowery Glass Co.

17. Father's Name (First, Middle, Last): Daniel A. Madison
18. Mother's Name (First, Middle, Maiden Surname): Gertrude Quinn

19a. Informant's Name/Relationship (Type, Print): Dayna Keiser (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2045 Putnam Road Baltimore, Maryland 21227

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Park
Date: 5/22/98
20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: McCully-Polyniak Funeral Home 237 E. Patapsco Avenue Balto., Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	NEUTROPENIA	1 WEEK
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	LUNG CANCER WITH METASTASIS	4 MONTHS
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] - MEDICINE RESIDENT
29c. License number: AS2441614-38
29d. Date signed (Month, Day, Year): MAY. 19. 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LIZY. B. THOMAS. HARBOR HOSPITAL CENTER. BALTIMORE. MD.

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998
32. Registrar's Signature: [signature] Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16050

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bernice Beatrice Miller

2. Date of Death Month / Day / Year: MAY 19 1998

3. Time of Death: 9:35 AM

4a. Facility Name *(If not institution, give street and number)*: CROFTON CONV. HOME

4b. City, Town, or Location of Death: CROFTON

4c. County of Death: ANNE ARUNDEL CO.

Funeral Director

5. Social Security Number: 213-22-4079

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 22, 1926

9. Birthplace *(State or Foreign Country)*: South Carolina

Usual Residence of Decedent

10e. State: Md.

10b. County: Anne Arundel

10c. City, Town or Location: Gambrills

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1604 Huntcliff Way

10f. Zip Code: 21054

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 8th; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: John Henry Layne

18. Mother's Name *(First, Middle, Maiden Surname)*: Bonnie Hampton

19a. Informant's Name/Relationship *(Type, Print)*: John K. Miller (Son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1604 Huntcliff Way Gambrills,Maryland 21054

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Memorial Park

Date: 5/21/98

20c. Location - City or Town, State: Elkridge,Maryland

21. Signature of Funeral Service Licensee: Louis S. Polyniak

22. Name and Address of Facility: McCully-Polyniak Funeral Home 237 E. Patapsco Ave. Balto., Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic obstructive pulmonary disease — 5 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D29571

29d. Date signed *(Month, Day, Year)*: 5/19/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL A. BEREZ, M.D. 1655 CROFTON BLVD. CROFTON, MD. 21114

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16051

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Paul M. Miller

2. Date of Death Month / Day / Year: May 17, 1998

3. Time of Death: 12:10 a.m.

4a. Facility Name *(If not institution, give street and number)*: Avalon Manor Nursing Home

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 219-20-3915

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: August 11, 1926

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 14014 Marsh Pike

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Painter

16b. Kind of Business/Industry: House Painter

17. Father's Name *(First, Middle, Last)*: Edward H. Miller

18. Mother's Name *(First, Middle, Maiden Surneme)*: Blanche C. Keefer

19e. Informant's Name/Relationship *(Type, Print)*: Doris J. Crouse/Sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 144 Buttercup Drive Hagerstown, MD 21740

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkhead Cemetery

Date: 5/20/98

20c. Location - City or Town, State: Big Pool, MD

21. Signeture of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Grove Funeral Home, P.A. 141 West Main Street Hancock, MD 21750-0368

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death)

a. Respiratory Failure — few min

Due to (or as a consequence of):

b. Congestive Heart Failure — 1 month

Due to (or as a consequence of):

c. Hypertensive Cardiovascular Disease — yrs

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last

Part II. **Other significant conditfona** contributing fo death but not resulting in the underlying cause given in Part I.

Chronic obstructive Pulmonary Disease

Chronic Renal insufficiency

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings aveiieble prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

28. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [ ] **Certifying Phyaicfan**: To the best of my knowledge, death occurred et the time, date and pieca, end due to the cause(s) and manner as stated. 2 [ ] **Medicaf Examiner**: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, dete end pieca, and due to the cause(s) and manner stated.

29b. Signature and titie of certifier: [signature] MD

29c. License number: D 18019

29d. Date signed *(Month, Day, Year)*: May 18 1998

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): Vasant Datta, M.D. 343 Mill St. Hagerstown, MD 21740

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 2 2 1998

32. Registrar's Signature: [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16052

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Katherine R. Meredith
2. Date of Death Month: May Day: 18 Year: 1998
3. Time of Death: 5:05 P.M.
4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218-09-5229
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 5, 1918
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 518 Oakwood Road
10f. Zip Code: 21061
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Grover Cleveland Richards
18. Mother's Name *(First, Middle, Maiden Surname)*: Amelia Baer

19a. Informant's Name/Relationship *(Type, Print)*: Robert Meredith/Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 518 Oakwood Road Glen Burnie, MD 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Glen Haven Mem. Pk. Date: May 21, 1998
20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funeral Service Licensee: Louis L. Edwards
22. Name and Address of Facility: Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. *Approximate Interval Between Onset and Death*

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS
Due to (or as a consequence of):
b. MYOCARDIAL INFARCTION
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D43977
29d. Data signed *(Month, Day, Year)*: May 18 1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Aryan Okeyungi. 301 Hospital Drive Glen Burnie. MD. 21061

State Registrar

31. Date Filed *(Month, Day, Year)*: MAY 22 1998
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Meredith, Katherine

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16053

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Miriam Meszaros
2. Date of Death (Month, Day, Year): May 18, 1998
3. Time of Death: 6:55 AM
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-26-5298
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEP 11, 1928
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3106 ½ Lynch Road
10f. Zip Code: 21219
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Store Clerk
16b. Kind of Business/Industry: Package Goods

17. Father's Name (First, Middle, Last): Jack Sterling
18. Mother's Name (First, Middle, Maiden Surname): Ruby Litteton

19a. Informant's Name/Relationship (Type, Print): James Meszaros/husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3106½ Lynch Rd. Baltimore, MD 21219

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc. Date: 05/19/98
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald
22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac Arrhythmia	mins.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Atherosclerotic Cardiovascular Disease	5 yrs.
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Robert C. Dart Jr M.D.
29c. License number: D39660
29d. Date signed (Month, Day, Year): May 19, 1998
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Robert C. Dart, Jr. 901 E. Fort Ave. Baltimore MD 21230

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 16054

Reg. No.

Amended Item#23aptll perPhyG773 7/9/99 EW

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Raymond NWACHUKWU - UDAKU
2. Data of Death — Month: MAY; Day: 15; Year: 1998
3. Time of Death: 17:49
4a. Facility Name *(If not institution, give street and number)*: THE JOHN HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: UNKNOWN
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 60 Yrs.
If Under 1 Year — Months: ; Days:
If Under 24 Hrs. — Hours: ; Min.:
8. Date of Birth *(Month, Day, Year)*: OCT 30, 1937
9. Birthplace *(State or Foreign Country)*: EZIALA -OGWU

Usual Residence of Decedent

10a. State: AFRICA
10b. County:
10c. City, Town or Location: NIGERIA
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: UNKNOWN
10f. Zip Code: UNKNOWN
10g. Citizen of What Country?: AFRICA- NIGERIA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] Yes 2 [ ] No *Specify:* AFRICA
14. Race - American Indian, Black, White, etc. *Specify:* AFRO AMERICAN

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MEDICAL PRACTITION
16b. Kind of Business/Industry: HOSPITAL

17. Father's Name *(First, Middle, Last)*: EZE NWACHUKWU - UDA
18. Mother's Name *(First, Middle, Maiden Surname)*: UNKNOWN

19a. Informant's Name/Relationship *(Type, Print)*: REV. DESMOND OHANKWERE FRIEND
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1501 E. OLIVER STREET, BALTIMORE, MARYLAND 21213

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: NGURU MBAISE IMO STATE
Date: 6/15/98
20c. Location - City or Town, State: NIGERIA, AFRICA

21. Signature of Funeral Service Licensee: EUGENE N. WALKER JR. MD00875
22. Name and Address of Facility: ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ADULT Respiratory Distress Syndrome — 1-day
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Lymphoma
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*:
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*:
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Steve Golden MD, PhD
29c. License number: B64576811
29d. Data signed *(Month, Day, Year)*: May 15, 1998
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Steve Golding MD - John Hopkins Hospital, Balto, MD

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 22 1998
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 16 Rev 6/95

98-2795-043
CMK
TAMMY L. NIPPER

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16055

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Tammy Lynn Nipper
2. Date of Death Month Day Year: MAY 17, 1998
3. Time of Death: 1715PM
4a. Facility Name (If not institution, give street and number): WASHINGTON COUNTY HOSPITAL
4b. City, Town, or Location of Death: HAGERSTOWN
4c. County of Death: WASHINGTON COUNTY

Funeral Director

5. Social Security Number: 212-82-7374
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 26 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 7, 1972
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington County
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: ☒ 1 Yes 2☐ No
10e. Street and Number: 125 B Buenavista Avenue
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unemployed
16b. Kind of Business/Industry: not applicable

17. Father's Name (First, Middle, Last): Dan R. Nipper
18. Mother's Name (First, Middle, Maiden Surname): Linda C. Bell

19a. Informant's Name/Relationship (Type, Print): Ms. Linda Nipper/mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 127B Buenavista Avenue, Hagerstown, MD 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Poplar Springs Cemetery
Date: 21MAY98
20c. Location - City or Town, State: Poplar Springs, MD

21. Signature of Funeral Service Licensee: [signature] M00535
22. Name and Address of Facility: Slack Funeral Home, P.A. Ellicott City, Maryland 21043

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Deeth

Immediate Ceuse (Final disease or condition resulting in deeth)
a. Contact Gunshot wound of Head
Due to (or as a consequence of):
b.
Due to (or as e consequence of):
c.
Due to (or as a consequenca of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? Partial 1☒ Yes 2☐ No
24b. Were autopsy findings eveileble prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☐ Natural 2☐ Accident 3☒ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year): 5-17-98
28b. Time of Injury: 16 10 M
28c. Injury et Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Subject shot self
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify): Construction site
28f. Location (Street and Number or Rural Route Number, City or Town, State): Campbell CT.

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as steted. 2☒ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.
29b. Signature and title of cartifier: [signature]
29c. License number: O.C.M.E.
29d. Date signed (Month, Dey, Year): MAY 18, 1998

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year): MAY 22 1998
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16056

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALINE B O'BRIEN
2. Date of Death Month MAY Day 21 Year 1998
3. Time of Death 0658
4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 500-32-9303
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 01/30/1909
9. Birthplace (State or Foreign Country): MISSOURI

Usual Residence of Decedent

10a. State: MD
10b. County: HOWARD
10c. City, Town or Location: COLUMBIA
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5423 CHATTERBIRD PLACE
10f. Zip Code: 21045
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): RETAIL CLERK
16b. Kind of Business/Industry: MENS WARE MERCHANDIZING

17. Father's Name (First, Middle, Last): WESLEY J. STATON
18. Mother's Name (First, Middle, Maiden Surname): MARY ELLA (LEVELLE)

19a. Informant's Name/Relationship (Type, Print): JEANNE A. WEINEL (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5423 CHATTERBIRD PLACE COLUMBIA, MD 21045

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crametory or other place): MEADOWRIDGE MEMORIAL PARK | Date: 5/23/98
20c. Location - City or Town, State: ELKRIDGE, MD

21. Signature of Funeral Service Licensee: ▶ Robert Gregory Burke
22. Name and Address of Facility: WITZKE FUNERAL HOMES, INC. 5555 TWIN KNOLLS ROAD COLUMBIA, MD 21045

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. end stage dementia — 3 yrs
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D37777
29d. Date signed (Month, Day, Year): 5/21/98
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PETER CHENG 2 KNOLL NORTH DR Columbia MD 21045

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998
32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16057

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marion A. Phelps
2. Date of Death: Month: May; Day: 21; Year: 1998
3. Time of Death: 4:10 pm
4a. Facility Name (If not institution, give street and number): 208 Middleway Rd. Apt. 1A
4b. City, Town, or Location of Death: Middle River
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218 01 3609
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct.12,1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Middle River
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 208 Middleway Rd. Apt. 1A
10f. Zip Code: 21220
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Edward Trockenbrot
18. Mother's Name (First, Middle, Maiden Surname): Edna Reck

19a. Informant's Name/Relationship (Type, Print): Linda Rodgers (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 201 Middleway Rd. Baltimore, Md. 21220

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Md. Veterans Cemetery
Date: 5/26/1998
20c. Location - City or Town, State: Garrison Forest, Md.

21. Signature of Funeral Service Licensee: John W. Burkowske
22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	CARCINOMATOSIS	1 year
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	BRONCHOGENIC CARCINOMA	1 year
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease
Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: N Gavhar MD
29c. License number: D 18326
29d. Date signed (Month, Day, Year): 5/22/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): N. GAVHAR, ESSEX MEDICAL CTR, 404 Eastern Blvd, Baltimore MD. 21221

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16058

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Preston H. Phillips, Jr
2. Date of Death: Month: May Day: 19 Year: 1998
3. Time of Death: 7:15 A.M
4a. Facility Name (If not Institution, give street and number): 2202 Wheatley Drive
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 215-30-3221
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2-11-1934
9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10e. State: Md
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2202 Wheatley Drive
10f. Zip Code: 21207
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12th grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: N.S.A

17. Father's Name (First, Middle, Last): Purcee Phillips
18. Mother's Name (First, Middle, Maiden Surname): Tu Bertha Bundidl

19a. Informant's Neme/Reletionship (Type, Print): Inez Phillips - wife
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 2202 Wheatley Drive Baltimore, Md 21207

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Garrison Forest Vet | Date: 5-26-98
20c. Location - City or Town, State: Owings Mills Md

21. Signature of Funeral Service Licensee: Lola March
22. Name end Address of Facility: Lola March F.H. West 4300 Wabash Avenue Ba Md 21215

Physician /Medical Examiner

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
e. C.O.P.D
Due to (or as e consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest
b. Pulmonary Hypertension
Due to (or es e consequence of):
c. Cor Pulmonale
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Raymond
29c. License number: D34184
29d. Date signed (Month, Day, Year): 5/19/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Raymond A. Ozem M.D., P.A., M.P.H. 7801 York Rd #300 Towson, MD 21204

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998
32. Registrar's Signature: Judith Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

5x1

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16059

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
MARGARET PRESSLEY	05	16	1998	4:10 AM.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
BON SECOURS HOSPITAL 2000 WEST BALTIMORE STR.	BALTIMORE	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-20-6187	1☐ M 2☒ F	71 Yrs.					1-17-1927	Md

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	NA	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2642 W. Lafayette Avenue	21216	U.S.A

11. Marital Status	12. Was Decedent Ever In U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)	Secretary	Church
12th grade	NA		

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Wallace Hall	Mary Holland

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216
Joseph B. Pressley - Husband	2642 W. Lafayette Avenue Balto, Md

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)	Garrison Forest	5-26-98	Owings Mills, Md 21215

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Dale March	March F.H. West 4300 Wabash Avenue Baltimore, Md

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pulmonary edema	2 days
	Due to (or es a consequence of):	
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last	b. Acute renal failure	3 days
	Due to (or as a consequence of):	
	c. Pneumonia	1 wk.
	Due to (or es e consequence of):	
	d. Metastatic rectal carcinoma	1 year.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Uterus cervix carcinoma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Phyaician:** To the best of my knowledge, deeth occurred et the time, date end piece, and due to the ceuse(s) end manner es steted.
2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, snd due to the cause(s) end manner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
A. Mrowiec M.D	D47 804	5/22/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. MROWIEC BON SECOURS HOSPITAL 2000 WEST BALTIMORE STR. BALTIMORE.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 1998	Gloria Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

4

8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16060

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ARTHUR R. POLLOCK

2. Date of Death Month / Day / Year: May 18, 1998

3. Time of Death: 8:49 AM

4a. Facility Name *(If not institution, give street and number)*: UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-18-0169

6. Sex: XX 1 M 2 F

7. Age *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 04-02-1923

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: XX 1 Yes 2 No

10e. Street and Number: 4004 ELKADER ROAD

10f. Zip Code: 21218

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 Nevar Married 2 Merried XX 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? XX 1 Yas 2 No If Yes, Give Yeer or Detes: 1943-1945

13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes XX 2 No *Specify:*

14. Rece - American Indian, Bleck, Whita, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 12 YEARS; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: POLICE OFFICER

16b. Kind of Business/Industry: FEDERAL GOVERMENT

17. Fethar's Nama *(First, Middla, Last)*: (UNK.) POLLOCK

18. Mother's Neme *(First, Middle, Maiden Sumama)*: ANNA MAE BIGGS

19a. Informent's Neme/Reletionship *(Type, Print)*: BONNIE J.TAYLOR (DAUGHTER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Steta, Zip Code)*: P.O.BOX 7,UPPER GLADE,W.VIRGINIA, 26266

20e. Method of Disposition: 1 Burial 2 XCremetion 3 Removal from Stata 4 Donetion 5 Other *(Specify)*

20b. Placa of Disposition *(Name of cemetery, cremetory or othar place)*: GREEN MOUNT CREMATORY

Date: 05/22/98

20c. Location - City or Town, Stata: BALTO.,MD.

21. Signature of Funaral Service Licensee: R. D. Rue

22. Name and Address of Facility: HENRY W.JENKINS AND SONS COMPANY 4905 YORK ROAD,BALTIMORE,MARYLAND,21212

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onsat and Deeth

Immediate Cause (Finel disease or condition resulting in death)

a. Progressive pulmonary failure — 3 days

Due to (or as e consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest

b.

Due to (or as e consequenca of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery Disease

Abdominal aortic aneurysm

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 X Probably 4 Unknown

24e. Wes en eutopsy performed? 1 Yes 2 X No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 Yes 2 X No

25. Wes case referred to medical examiner? 1 X Yes 2 No

26. Piece of Death *(Check only one)*: Hospitel: 1 X Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residenca 6 Other *(Specify)*

27. Menner of Deeth: 1 X Naturel 2 Accident 3 Suicide 4 Homicide 5 Pending Investigetion 6 Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, factory, office buiiding, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 X **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) end menner es stated. 2 **Medical Examiner:** On tha basis of exemination end/or investigation, in my opinion, death occurred et the time, date and pieca, and due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: MD

29c. Licensa number: AT2438948

29d. Date signed *(Month, Day, Year)*: May 18, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Nomi Shapal MD.. The Union Memorial Hospital Baltimore MD

State Registrar

31. Dete filed *(Month, Dey, Year)*: MAY 2 2 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Arthur R. Pollock

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16061

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Savita Patel

2. Date of Death (Month, Day, Year): May 19, 1998

3. Time of Death: 7:45 AM

4a. Facility Name (If not institution, give street and number): 10894 Harmel Drive

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 218-94-7884

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 14, 1915

9. Birthplace (State or Foreign Country): India

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 10894 Harmel Drive

10f. Zip Code: 21044

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Asian-Indian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Chhotabhai Patel

18. Mother's Name (First, Middle, Maiden Surname): Kashiba Patel

19a. Informant's Name/Relationship (Type, Print): Bhasker Patel/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21405 Manor View Circle Germantown, MD 20876

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Metro Crematory, Inc. Date: 5/22/98

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik
Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Dilated Cardiomyopathy — Years

Due to (or as a consequence of):
b. Coronary Artery Disease — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atrial Fibrillation, Obstructive Lung Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☑ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: F De Le

29c. License number: D46120

29d. Date signed (Month, Day, Year): May 19, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Fernando DeLeon, MD 10724 Little Patuxent Parkway Columbia, MD 21044

State Registrar

31. Date filed (Month, Day, Year): MAY 2 2 1998

32. Registrar's Signature: Erika Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16062

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John F. Peterson, Sr.
2. Date of Death Month / Day / Year: May 19 1998
3. Time of Death: 8:30 PM
4a. Facility Name *(If not institution, give street and number)*: Canton Harbor Health Care
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-20-9737
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov 28 1910
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: N/A
10c. City, Town or Location: Baltimore, Md.
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 442 N. Lakewood Avenue
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th — College (1-4or 5+): N/A
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver
16b. Kind of Business/Industry: Distributor Co.

17. Father's Name *(First, Middle, Last)*: John Peterson
18. Mother's Name *(First, Middle, Maiden Surname)*: Ella Neary

19a. Informant's Name/Relationship *(Type, Print)*: Lorraine Peterson/wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 442 N. Lakewood Ave. Baltimore, Md. 21224

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holly Hills Cem. — Date: 5/22
20c. Location - City or Town, State: Baltimore Co.

21. Signature of Funeral Service Licensee: Hartley Miller
22. Name and Address of Facility: Hartley Miller Funeral Home, CHTD. 7527 Harford Rd. Baltimore, Md. 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular accident
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus; Atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marvin Kornblatt MD
29c. License number: D21022
29d. Date signed *(Month, Day, Year)*: 5-21-98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): M. Kornblatt 8604 Harford Rd Balto MD 21234

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16063

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY R RHODES
2. Date of Death — Month: MAY; Day: 19; Year: 1998
3. Time of Death: 12:40 AM
4a. Facility Name *(If not Institution, give street and number)*: HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 225-26-6642
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 14, 1926
9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Md.
10b. County: Anne Arundel
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 408 Townsend Avenue
10f. Zip Code: 21225
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Spacify only highast grada completed)*: Elementery/Secondary (0-12): 8th; College (1-4or 5+): 0
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Walter D. Scott
18. Mother's Name *(First, Middle, Maiden Sumame)*: Roxye L. Phillips

19a. Informant's Name/Reletionship *(Type, Print)*: Edna Williamson (Cousin)
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13417 Wheelers Pond Road DeWitt, Va. 23840

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, crematory or other pleca)*: Cedar Hill Cemetery
Date / 20c. Location - City or Town, State: 5/21/98 Baltimore, Maryland

21. Signature of Funeral Service Licensaa: Kevin E. Ecker
22. Name and Address of Facility: McCully-Polyniak Funeral Home' 237 E. Patapsco Ave. Balto., Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina.

		Approximete Interval Between Onset and Deeth
Immediete Cause (Finai disease or condition resulting in death) e.	BREAST CANCER	12 YEARS
Due to (or as a consequence of):		
b.	RENAL FAILURE	1 WEEK
Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest — Due to (or es a consequenca of): c.	HYPERTENSION	> 1 YEAR
Due to (or as e consequence of): d.	DIABETES MELLITUS	> 1 YEAR

Part II. **Othar significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Deeth: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Straet and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end placa, end dua to the cause(s) snd menner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, In my opinion, deeth occurred at the time, date and piace, and due to tha causa(s) and menner stated.

29b. Signature and title of cartifier: Lizy Thomas, MEDICINE RESIDENT
29c. License number: AS 244614-38
29d. Data signed *(Month, Day, Year)*: MAY, 19- 1998

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): LIZY. B. THOMAS, HARBOR HOSPITAL CENTER, BALTIMORE, MD

State Registrar

31. Dete filed *(Month, Dey, Year)*: MAY 22 1998
32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed and
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16064

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET M. ROMANS
2. Data of Death (Month, Day, Year): May 19, 1998
3. Time of Death: 4:35 PM
4a. Facility Name (If not institution, give street and number): Stella Maris
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-03-0427
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 3, 1908
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3506 Cardenas Ave.
10f. Zip Code: 21213
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: State of Maryland

17. Father's Name (First, Middle, Last): Charles Kurzmiller
18. Mother's Name (First, Middle, Maiden Surname): Antonia Gutsmeild

19a. Informant's Name/Relationship (Type, Print): Mr. Michael J. Romans/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26 Perry Falls Place Baltimore, Md. 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Joseph Fullerton
Date: 5/22/98
20c. Location - City or Town, State: Perry Hall, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASCVD
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D25687
29d. Date signed (Month, Day, Year): 5-20-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EBRAHIM IPAKCHI 7600 OSLER DRIVE BALTIMORE MD 21204

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998
32. Registrar Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Rita F. Robertazzi

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16065

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rita Santella Robertazzi
2. Date of Death Month / Day / Year: May 19, 1998
3. Time of Death: 10:50 p.m.
4a. Facility Name *(If not institution, give street and number)*: 253 Marganza South
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 207-22-8075
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 11,1929
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 253 Marganza South
10f. Zip Code: 20724
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): Ø
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Luigi Turso
18. Mother's Name *(First, Middle, Maiden Surname)*: Santella Cacchio

19a. Informant's Name/Relationship *(Type, Print)*: Michael A. Robertazzi/Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 253 Marganza South, Laurel, Maryland 20724

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Calvary Cemetery
Date: 5/23/98
20c. Location - City or Town, State: Altoona, PA

21. Signature of Funeral Service Licensee: Steven Williams
22. Name and Address of Facility: Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Respiratory Failure	24hrs.
	Due to (or as a consequence of):	
	b. Aspiration Pneumonia	1wk
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	c. Breast cancer metastatic to brain lung	6 yrs
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic anemia,

Anorexia / cachexia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jon K. Mumford MD.
29c. License number: D30573
29d. Date signed *(Month, Day, Year)*: 5-20-98.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jon Mumford 11065 Little Patuxent Parkway, Columbia, MD 21044.

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1998
32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16066

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EURITH R. ROOP

2. Date of Death (Month, Day, Year): MAY 20 1998

3. Time of Death: 6:20am

4e. Facility Name (If not institution, give street and number): ROLAND PARK PLACE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-52-9812

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 99 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 04-22-1899

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10e. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 830 WEST 40TH STREET

10f. Zip Code: 21211

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: HOMEMAKER

17. Father's Name (First, Middle, Last): CHARLES DUDLEY ROSE

18. Mother's Name (First, Middle, Maiden Surname): SUSAN JEFFIERS

19a. Interment's Name/Relationship (Type, Print): MARY DUDLEY OBRECHT(NEICE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15321 FALLS RD. SPARKS,MD. 21152.

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): LORRAINE PARK | Date: 05/22/98

20c. Location - City or Town, State: BALTO.,MD.

21. Signature of Funeral Service Licensee: William L. Austin

22. Name and Address of Facility: HENRY W. JENKINS & SONS 4905 YORK RD. BALTO.,MD. 21212.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerdiopulmmary Arrest

Due to (or as a consequence of):
Arteriosclerosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hiatal Hernia Neuropathy
Osteoarthritis
Depression.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: D Dow

29c. License number: D37133

29d. Date signed (Month, Day, Year): 5/20/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DONNA DOW M.D. 7600 OSLER DRIVE SUITE 209 TOWSON,MD. 21204.

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998

32. Registrar's Signature: Julia Davidson-Randall

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16067

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Rogers
2. Date of Death (Month, Day, Year): MAY 19 1998
3. Time of Death: 09:55 AM
4a. Facility Name (If not Institution, give street and number): JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 267 40 1505
6. Sex: 1 # M 2 ☐ F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10/13/34
9. Birthplace (State or Foreign Country): FLORIDA

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 # Yes 2 ☐ No
10e. Street and Number: 1622 E. BELVERDERE AVE.
10f. Zip Code: 21239
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 # Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 # Yes 2 ☐ No If Yes, Give Year or Dates: 7/53 1/56
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 # No Specify:
14. Race - American Indian, Black, White, etc. Specify: AFRO AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DIETARY SECURITY OFFICER
16b. Kind of Business/Industry: MD. D.O.C.

17. Father's Name (First, Middle, Last): LORENZO ROGERS
18. Mother's Name (First, Middle, Maiden Surname): VERA GIBBONS

19a. Informant's Name/Relationship (Type, Print): SHIRLEY G. ROGERS WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1622 E. BELVERDERE AVE. BALTO. MD. 21239

20a. Method of Disposition: 1 # Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST V.A.
Date: 5/26/98
20c. Location - City or Town, State: OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee: Ceall Daly
22. Name and Address of Facility: ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pneumonia	2 days
Due to (or as a consequence of): b.	Small Bowel Obstruction	2 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Colon Cancer	2 years
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation
Hypertension
Diverticulosis

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Alix Lamoue M.D
29c. License number: RES-000
29d. Date signed (Month, Day, Year): May 19, 1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alix Lamoue Tower 110 Johns Hopkins Hospital Balto MD

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998
32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be prepared within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16068

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GLADYS REGINA TURNBAUGH SEHLHORST
2. Date of Death (Month, Day, Year): May 19, 1998
3. Time of Death: 1:15 P.M.
4a. Facility Name *(If not institution, give street and number)*: CARDINAL SHEHAN CENTER FOR THE AGING
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 212-74-1219
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 98 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb 14, 1900
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Virginia
10b. County: Fairfax
10c. City, Town or Location: Annandale
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7838 Birds Nest Pass
10f. Zip Code: 22003
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Residence

17. Father's Name *(First, Middle, Last)*: Jacob Malcolm Turnbaugh
18. Mother's Name *(First, Middle, Maiden Surname)*: Agnes Cecelia Trainor

19a. Informant's Name/Relationship *(Type, Print)*: Barbara R. Nyce, (Niece & P.R.)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7838 Birds Nest Pass, Annandale, VA 22003

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: New Cathedral Cemetery | Date: 5/26/98
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Martin D. Lawson
22. Name and Address of Facility: Mitchell-Wiedefeld Home, 6500 York Road, Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D32543
29d. Date signed *(Month, Day, Year)*: 5/20/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mark R. Stomberg, M.D., 7505 Osler Drive, Towson, Maryland 21204

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16069

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Emma Christine Maxwell Spencer

2. Dete of Deeth — Month: May; Dey: 21; Yeer: 1998

3. Time of Death: 5:30 AM

4e Facility Neme *(If not institution, give street end number)*: 204 Gittings Avenue

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-01-2101

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthdey)*: 82 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: January 5 1916

9. Birthplace *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 204 Gittings Avenue

10f. Zip Code: 21212

10g. Citizen of Whet Country?: United States

11. Meritel Status: 1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Reca - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent'e Educetion *(Specify only highest grede completed)*: Elementery/Secondary (0-12); College (1-4or 5+): 2

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Neme *(First, Middle, Last)*: Edward Stabler Maxwell

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Ruby Emma Harris

19e. Informent's Neme/Reletionship *(Type, Print)*: Julian M. Spencer, Sr./Husband

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 204 Gittings Avenue Baltimore, MD 21212

20e. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Plece of Disposition *(Neme of cemetery, cremetory or other piece)*: Greenmount Crematory

Dete: 5-26-98

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signeture of Funerel Servica Licensee: ▶ Steven T. Zilch

22. Neme end Address of Facility: Mitchell-Wiedefeld Home, Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List *only* one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in deeth)

e. Acute myocardial infarction

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest

b.

Due to (or es e consequenca of):

c.

Due to (or es e consequenca of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Pneumonia

Atrial fibrillation

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveileble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

28. Place of Deeth *(Check only one)*

Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of exemination and/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: ▶ JC Attending MD

29c. License number: 037016

29d. Date signed *(Month, Day, Year)*: May 21, 1998

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print): Kenneth M. Greene, M.D. 6701 N. Charles St. Suite 4105 Towson, MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 2 2 1998

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16070

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Tilton Bailey Smith
2. Date of Death: Month May Day 19 Year 1998
3. Time of Death: 11 07 PM
4a. Facility Name (If not institution, give street and number): Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 240 14 1679
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months ___ Days ___
If Under 24 Hrs.: Hours ___ Min. ___
8. Date of Birth (Month, Day, Year): Jan. 20, 1919
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 717 Melville Ave.
10f. Zip Code: 21218
10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Analyzer
16b. Kind of Business/Industry: Chemical Plant

17. Father's Name (First, Middle, Last): Dolphus Smith
18. Mother's Name (First, Middle, Maiden Surname): Bertha (Unknown)

19a. Informant's Name/Relationship (Type, Print): Diane Smith / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 717 Melville Ave., Baltimore, MD 21218

20a. Method of Disposition: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory Date: 5/22/98
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Stephen D Lohrmann
22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Pneumonia	10 days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Aspiration	10 days
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Immobility syndrome

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Anthony Dorsey, MD
29c. License number: AT2438946
29d. Date signed (Month, Day, Year): May 19, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anthony Dorsey Union Memorial Hospital Baltimore, Md.

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Tilton B. Smith

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16071

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES ERNEST SANTMYER

2. Date of Death: Month MAY Day 20, Year 1998

3. Time of Death: 3:30 P.M.

4a. Facility Name *(If not institution, give street and number)*: 905 GROVEHILL ROAD

4b. City, Town, or Location of Death: ARBUTUS

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-01-8472

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: FEB 19, 1916

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: ARBUTUS

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 905 GROVEHILL ROAD

10f. Zip Code: 21227

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9TH GRADE | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: POLICE OFFICER

16b. Kind of Business/Industry: LAW ENFORCEMENT

17. Father's Name *(First, Middle, Last)*: WARREN SANTMYER

18. Mother's Name *(First, Middle, Maiden Surname)*: MYRTLE WOLFE

19a. Informent's Name/Relationship *(Type, Print)*: JoANN NELSON (DAUGHTER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 108 STARHILL LANE - CATONSVILLE, MD 21228

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: BALTIMORE NATIONAL CEM

Date: 5/26/98

20c. Location - City or Town, State: BALTIMORE

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in deeth)

a. RESPIRATORY FAILURE — 1 DAY

Due to (or as a consequence of):

b. Widely METASTATIC SQUAMOUS Cell CARCINOMA — 2 YEARS

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest

Due to (or es a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SEVERE EMPHYSEMA. CORONARY HEART DISEASE. CRIPPLING DEGENERATIVE ARTHRITIS. ANEMIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] ATTENDING

29c. License number: D16200

29d. Date signed *(Month, Day, Year)*: MAY 22, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. NORBERTO M. MACHIRAN - 720 "C" MAIDEN CHOICE LANE - CATONSVILLE, MD 21228

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1998

32. Registrar Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6x1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16072

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: MAXINE GENEVA SWAIN

2. Dete of Deeth — Month: MAY Day: 16 Year: 1998

3. Time of Death: 2:50 PM

4a. Facility Neme *(If not institution, give street end number)*: WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death: HAGERSTOWN MD.

4c. County of Deeth: WASHINGTON CO.

Funeral Director

5. Social Security Number: 219-20-3881

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthday)*: 83 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: 4/10/1914

9. Birthplece *(Stete or Foreign Country)*: MD

Usual Residence of Decedent

10e. Stete: MD

10b. County: WASHINGTON

10c. City, Town or Location: HANCOCK

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 14625 HIGH GERMANY RD.

10f. Zip Coda: 21750

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rlcen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Amarican Indlen, Bleck, Whita, etc. *Specify:* CAUC.

15. Decedent's Eaucetion *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+):

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cook

16b. Kind of Business/Industry: Washington County Board of Education

17. Father's Neme *(First, Middle, Last)*: Cecil Schriver

16. Mother's Neme *(First, Middle, Meiden Surneme)*: Russcella Hill

19a. Informent's Neme/Relationship *(Type, Print)*: James W. Swain/Son

19b. Meiling Address *(Street end Number or Rural Routa Number, City or Town, Stete, Zip Code)*: 13459 Millstone Circle Hancock, MD 21750

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Remove! from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cramatory or other piece)*: Piney Plains U.M.Cememetry — Dete: 5/19/98

20c. Location - City or Town, Stata: Little Orleans, MD

21. Signature of Funeral Service Licensee: Richard L. Grove

22. Nama and Address of Facility: Grove Funeral Home, P.A. 141 West Main Street Hancock, MD 21750-0368

Physician /Medical Examiner

23a. Pert1. Enter the diseasa, or complications that caused the death. Do not entar tha mode of dying, such es cerdiec or raspiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximete Intarvel Between Onsat and Deeth

Immediete Ceuse (Finel diseese or condition resulting in death)

e. INCREASED INTRACRANIAL PRESSURE

Due to (or es e consequence of):

Sequentlelly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Disaase or injury thet initiated events resulting in deeth) Last

b. CEREBRAL INFARCTION

Dua to (or es e consequence of):

c. OCCLUSION LEFT INTERNAL CAROTID ARTERY

Due to (or es a consequence of):

d. ARTERIO SCLEROSIS

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings availeble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

26e. Dete of Injury *(Month, Dey Year)*

26b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

26e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

26f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner stated.

29b. Signature and title of certifier: Edward Byrd M.D.

29c. License number

29d. Date signed *(Month, Dey, Year)*: 5/16/98

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): 11110 MEDICAL CAMPUS RD. SUITE 104 HAGERSTOWN MD. 21742

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 22 1998

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Swain, Maxine Geneva

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16073

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cheryl A. Shakboua-Gibson

2. Date of Death — Month: May Dey: 12 Yeer: 1998

3. Time of Death: 5:38 P.M.

4a. Facility Name (If not institution, give street and number): 7605 Greenbrook Drive

4b. City, Town, or Location of Death: Greenbelt

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 510 58 3047

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 43 Yrs.

If Under 1 Year — Months: Deys:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Dey, Year): Oct. 24, 1954

9. Birthplece (State or Foreign Country): Missouri

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Greenbelt

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 7605 Greenbrook Drive

10f. Zip Code: 20770

10g. Citizen of Whet Country?: United States

11. Mertel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed) — Elementery/Secondery (0-12): 4 College (1-4or 5+):

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): William E. Crust

18. Mother's Neme (First, Middle, Meiden Surname): Shirley R. Kempton

19a. Informent's Name/Reletionship (Type, Print): William A. Gibson Husband

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 7605 Greenbelt Drive Greenbelt Maryland 20770

20e. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): The Huntt Crematory Date: May 17 1998

20c. Location - City or Town, Stete: Waldorf Maryland

21. Signature of Funerel Service Licensee: Michael L. Bigler

22. Neme end Address of Fecility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dyirg, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in death): e. Bolleous Concussion — 3 hours

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest:

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uas contributs to the causs of death? 1☐ Yss 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings aveileble prior to completion of cause of deeth? 1☐ Yes 2☑ No

25. Was case referred to medical exeminer? 1☐ Yes 2☑ No

26. Piece of Deeth (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of exemineticn end/or investigetion, in my opinion, death occurred et the time, dete end piece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier:

29c. License number: D16410

29d. Dete signed (Month, Dey, Year): 5.14.98

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): Gabriel B. Jaffe M.D. 7500 Hanover Parkway Greenbelt Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State Registrar

31. Dete filed (Month, Day, Yeer): MAY 22 1998

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16074

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lorraine Smith-Kiel

2. Date of Death (Month, Day, Year): May 16 1998

3. Time of Death: 5:15 PM

4a. Facility Name (If not institution, give street and number): St. Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-14-4726

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct 18 1919

9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Md

10b. County: N/A

10c. City, Town or Location: Baltimore, Md.

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3120 Harview Avenue

10f. Zip Code: 21234

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 th | College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Cliffton C. Cook

18. Mother's Name (First, Middle, Maiden Surname): Margaret A. Baker

19a. Informant's Name/Relationship (Type, Print): Ms Diane McClain

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3120 Harview Ave. Baltimore, Md. 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith | Date: 5/19/98

20c. Location - City or Town, State: Baltimore

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Hartley Miller Funeral Home, Chtd. 7527 Harford Rd. Baltimore, Md. 21234

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. NEUROMUSCULAR DISORDER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. BRONCHOPNEUMONIA. — years — days

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ceballos MD

29c. License number: D-25886

29d. Date signed (Month, Day, Year): 5-19-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lilia Ceballos, M.D., 7620 York Road, Towson, Md. 21204

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16075

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Pearl M. Tolen	May 9, 1998	11:25 p.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Laurel Regional Hospital	Laurel	Prince George

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
263-38-0316	1☐ M 2☒ F	81 Yrs.			Dec. 14, 1916	Georgia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George	Laurel	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
14814 Belle Ami Drive	20707	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10	Ø	Factory Worker	Clothing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Harrell	Anna Kate Peacock

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Charlie Peel/Son	14814 Belle Ami Drive, Laurel, Maryland 20707

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Maryland Nat'l Mem. Prk.	5/15/98	Laurel, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Steven Fleck	Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory failure

Due to (or as a consequence of):
b. pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Gastrointestinal bleed
Anemia
Alzheimer's disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Mark D Goldman MD	D 22123	5/10/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mark D. Goldman, M.D. 8317 Cherry Lane, Laurel, Maryland 20708

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16076

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edna Marie Tyler

2. Data of Death — Month: May Day: 16 Year: 1998

3. Time of Death: 7:45 A.M.

4a. Facility Name (If not institution, give street and number): 12501 Caswell Lane

4b. City, Town, or Location of Death: Bowie

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 215 58 9892

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Feb. 21, 1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Bowie

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 12501 Caswell Lane

10f. Zip Code: 20715

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No — If Yes, Give Year or Dates: XX

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: X

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 8 — College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Theodore Tyler

18. Mother's Name (First, Middle, Maiden Surname): Grace Lewis

19a. Informant's Name/Relationship (Type, Print): Grace Busse Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12501 Caswell Lane Bowie Maryland 20715

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery — Date: May 19, 1998

20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Michael L Bijl

22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Lung Cancer — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ruth Gallant MD

29c. License number: D0052089

29d. Date signed (Month, Day, Year): 5/18/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ruth Gallant, MD 3231 Superior Lane, A-6, Bowie, MD 20715 (20715)

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16077

Amend: #8 Per FH Film G761 7-24-98RC

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLINTON RANDOLPH TAYLOR

2. Date of Death: Month MAY Day 17, Year 1998

3. Time of Death: 4:24 P.M.

4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 236-18-5970

6. Sex: XX 1 M 2 F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. ~~20~~ 11, 1920

9. Birthplace (State or Foreign Country): W. Va.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Kingsville

10d. Inside City Limits: 1 Yes 2 XX No

10e. Street and Number: 7011 Heathcoate Dr.

10f. Zip Code: 21087

10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1 Never Married 2 XX Married 3 Widowed 4 Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 yrs.

Collage (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Self-Employed

16b. Kind of Business/Industry: Sexauer Plumbing Co.

17. Father's Neme (First, Middle, Last): Albert C. Taylor

18. Mother's Name (First, Middle, Maiden Sumame): Lovey Eubank

19a. Informent's Name/Relationship (Type, Print): Mary E. Taylor (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7011 Heathcoate Dr. Kingsville, Md. 21087

20a. Method of Disposition: 1 Buriel 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Metro Crematory Inc. Date: 5-19-98

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: E. F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md.21087

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha daath. Do not anter the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one cause on each line.

Approximate Interval Batween Onset and Death

Immediata Cause (Final disease or condition resulting in death): a. ACUTE MYOCARDIAL INFARCTION — 12 HOURS

Dua to (or as a consequance of):

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: PNEUMONIA

23b. Did tobacco use contribute to the causs of death? 1 Yss 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Ware autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Othar (Specify)

27. Manner of Death: 1 X Natural 2 Accidant 3 Suicide 4 Homicida 5 Pending invastigation 6 Could not be datarmined

28a. Deta of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Placa of injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifiar (Check only one): 1 X Certifying Physician: To the best of my knowledga, death occurred at the time, date end place, and due to tha causa(s) and manner as steted. 2 Medical Examiner: On tha basis of axamination and/or investigation, in my opinion, daath occurred at the tima, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: RD 18561 1

29d. Date signed (Month, Day, Year): 5/17/1998

30. Nama and address of parson who compiatad causa of death (Item 23a) (Type, Print): DR. JAMES ORFORD 9000 FRANKLIN SQUARE DR. BALTIMORE, MARYLAND 21221

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CLINTON TAYLOR

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16078

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Catherine Virginia Thomas
2. Date of Death Month: MAY Day: 18 Year: 1998
3. Time of Death: 11:02 AM
4a. Facility Name *(If not institution, give street and number)*: St. Agnes Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-32-7944
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 65 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: SEP 22, 1932
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 11 Fusting Avenue
10f. Zip Code: 21228
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Theodore Christian Brunn
18. Mother's Name *(First, Middle, Maiden Surname)*: Agnes Dyson

19a. Informant's Name/Relationship *(Type, Print)*: William J. Thomas/son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 125 Maple Ave. Catonsville, MD 21228

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Good Shepherd Cemetery — Date: 5/22/98
20c. Location - City or Town, State: Ellicott City, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Name and Address of Facility: MacNabb Funeral Home, P.A. 301 Frederick Rd. Baltimore, MD 21228

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pulmonary Embolism	Hours
Due to (or as a consequence of): b.	Chronic Renal failure.	Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Anemia.	Years
Due to (or as a consequence of): d.	Bilat. ureteric stenosis	Yrs

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mohammad Saleem
29c. License number: D40610
29d. Date signed *(Month, Day, Year)*: May 18, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MOHAMMAD SALEEM, ST. AGNES HOSP. Emergency Room.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Name. Catherine Virginia Thomas

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State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16079

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROBERT JULLIARD VERNIER
2. Date of Death Month Day Year: MAY 19, 1998
3. Time of Death: 6:30 AM
4a. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 715-01-2991
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 78 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 1,1920
9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Overlea/Fullerton
10d. Inside City Limits: 1 [ ] Yes [X] No
10e. Street and Number: 16 Belhaven Drive
10f. Zip Code: 21236
10g. Citizan of What Country?: USA

11. Marital Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No
If Yes, Give Yaar or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Engineer
16b. Kind of Business/Industry: Martin Marietta

17. Father's Nama *(First, Middle, Last)*: Elon Vernier
18. Mother's Name *(First, Middle, Maidan Surname)*: Gertrude Julliard

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Elizabeth F. Vernier
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 16 Belhaven Drive Baltimore, Maryland 21236

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gardens of Faith Cemetery
Date: 5-22-98
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failura. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

END STAGE PARKINSON'S DISEASE

DEHYDRATION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yee 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy tindings available prior to compiation of ceuse of death? 1 [ ] Yes 2 [X] No

25. Was cese relerred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Data of Injury *(Month, Dey Year)*
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis ot examination and/or Investigetion, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. Licensa number: D 37254
29d. Date signed *(Month, Day, Year)*: 5-19-98

30. Name and address ol person who completed cause of death (Item 23a) (Type, Print): BOON P. LIM, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar

31. Date liled *(Month, Day, Year)*: MAY 22 1998
32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Item#4a,8 per FH G759 5/22/98 FW

Reg. No. 98 16080

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Death Month	Day	Year	3. Time of Death
MARY		WILKINS	MAY	19	1998	17

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Mariner Nursing Home - Belair ~~410 S. McPHAIL ST~~	BELAIR	HARFORD

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-07-1268	1☐ M 2☒ F	78 Yrs.					06-21 ~~1998~~ 1919	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Abingdon	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
311-B Laurelwood Drive	21009	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11 Years	---------	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Frank Strozykowski	Anna Janowski

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Robert P. Wilkins-Son	311-B Laurelwood Drive Abingdon, MD 21009

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Gardens Of Faith Cem.	5-22-98	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
J. Wayne Osterling	Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA Right lower Lobe.	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ASVD

DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	NA	NA M	1☐ Yes 2☒ No	NA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
NA	NA

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
DME	OCME	MAY 19 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G.S. PAARHW. MD 218 FOLKSTONE AVE BELAIR MD 21014

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 1998	Trina Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

WILKINS MARY T.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16081

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN A. WORTHINGTON
2. Date of Death (Month, Day, Year): MAY 19 1998
3. Time of Death: 6:52 PM
4a. Facility Name (If not institution, give street and number): STELLA MARIS HOSPICE
4b. City, Town, or Location of Death: TIMONIUM
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 220-54-9954
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 47 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8/22/50
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: TOWSON
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1152 E. GYPSY LANE
10f. Zip Code: 21286
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th GRADE | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CONTRACTOR
16b. Kind of Business/Industry: SELF EMPLOYED

17. Father's Name (First, Middle, Last): HOWARD WORTHINGTON
18. Mother's Name (First, Middle, Maiden Surname): ANNA KATHARYN WAGNER

19a. Informant's Name/Relationship (Type, Print): ROBERT WORTHINGTON BROTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2117 WOODFORK ROAD TIMONIUM, MD 21093

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY, INC.
Date: 5/21/98
20c. Location - City or Town, State: CATONSVILLE, MD

21. Signature of Funeral Service Licensee: Heather N. Hays
22. Name and Address of Facility: JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. RENAL CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Penelope Edwards MD
29c. License number: D44128
29d. Date signed (Month, Day, Year): May 20, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Penelope Edwards 2300 Dulaney Valley Rd. Timonium MD 21093

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16082

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOROTHY WENICK
2. Date of Death: Month 5 Day 15 Year 1998
3. Time of Death: 8:15 AM
4a. Facility Name (If not institution, give street and number): 19120 Muncaster Road (Sycamore Acres)
4b. City, Town, or Location of Death: Derwood
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 138-38-0009
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 9, 1906
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Derwood
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 19120 Muncaster Road (Sycamore Acres)
10f. Zip Code: 20855
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 1 Year
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Abraham Greenberg
18. Mother's Name (First, Middle, Maiden Surname): Minnie Gottlieb

19a. Informant's Name/Relationship (Type, Print): Martin Wenick, Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3919 Watson Place, NW, Washington, D.C. 20016

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Solomon Cemetery — Date: May 18, 1998
20c. Location - City or Town, State: Clifton, New Jersey

21. Signature of Funeral Service Licensee: ▶ Donald C. Stottlemyer
22. Name and Address of Facility: STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, NW, WASHINGTON, DC 20012

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Aspiration Pneumonia	2 days
Due to (or as a consequence of): b.	Esophageal Cancer	2 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Barrett's Esophagus	
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Richard Schubert
29c. License number: 11441
29d. Date signed (Month, Day, Year): May 15, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard D. Schubert, M.D., 3301 New Mexico Avenue, N.W., #348, Washington, D.C. 20016

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16083

Certificate of Death

Reg. No.

Woods, Mark
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARK WOODS
2. Date of Death: Month MAY Day 19 Year 1998
3. Time of Death: 6:10 AM
4a. Facility Name (If not institution, give street and number): Deaton Medical Center and Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 255-78-5086
6. Sex: 1 M 2 F: X
7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT 29, 1948
9. Birthplace (State or Foreign Country): UNK.

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: X 1 Yes 2 No
10e. Street and Number: 611 S. Charles Street
10f. Zip Code: 21230
10g. Citizen of What Country: USA

11. Marital Status: 1 X Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): UNK. College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Disabled
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): UNK.
18. Mother's Name (First, Middle, Maiden Surname): UNK.

19a. Informant's Name/Relationship (Type, Print): Mary Connor/Guardian
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 300 Metro Plaza Baltimore, MD 21215

20a. Method of Disposition: 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.
Date: 5/20/98
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald
Dawn F. McDonald
22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Colon Cancer — 10 months
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23b. **Did tobacco use contribute to the cause of death?** 1 X Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA; Other: 4 X Nursing Home 5 Residence 6 Other (Specify)
27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D38675
29d. Date signed (Month, Day, Year): 5/19/98
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOEL MESHULAM 1147 S HANOVER STREET BALTIMORE MD 21230

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

1 X 1

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16084

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Zimmerman

2. Date of Death — Month: May; Day: 17; Year: 1998

3. Time of Death: 4.30 PM

4a. Facility Name *(If not institution, give street and number)*: St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-07-6882

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: APR 6, 1918

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Anne Arundel

10c. City, Town or Location: Linthicum

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 286 Church Circle

10f. Zip Code: 21090

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Anthony Sorrentino

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Maggio

19a. Informant's Name/Relationship *(Type, Print)*: Sharon Miller - daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6623 Cambria Terr., Elkridge, Md. 21075

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Mem. Park

Date: 5/23/98

20c. Location - City or Town, State: Elkridge, Md.

21. Signature of Funeral Service Licensee: Laura Dexter

22. Name and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC BREAST CANCER — YR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D44701

29d. Date signed *(Month, Day, Year)*: May 17, 98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAIRACH PINTAVORN, MD — St. Agnes Hospital 900 CATON AVE Baltimore, MD

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME ZIMMERMAN, MARY

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16085

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lucy Zelko

2. Date of Death Month May Day 21 Year 1998

3. Time of Death: 6:42 A.M.

4a. Facility Name (If not institution, give street and number): 14403 Mt. Oak Road

4b. City, Town, or Location of Death: Mitchellville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 213 38 4768

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 11, 1917

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Mitchellville

10d. Inside City Limits: 1☐ Yes 2☐ No XX

10e. Street and Number: 14403 Mt. Oak Road

10f. Zip Code: 20721

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 4
College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer

16b. Kind of Business/Industry: Farming

17. Father's Name (First, Middle, Last): Walter Carrick

18. Mother's Name (First, Middle, Maiden Surname): Blanche Cole

19a. Informant's Name/Relationship (Type, Print): Larry Case Son-In-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 1475 Bowie Maryland 20717

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Oak Church Cemetery Date: May 25, 1998

20c. Location - City or Town, State: Mitchellville Maryland

21. Signature of Funeral Service Licensee: Michael L Bigler

22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cerebrovascular accident — Hours

Due to (or as a consequence of):
b. Hypertension — Many years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic obstructive pulmonary disease, coronary artery disease.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Tara T Muscovich MD

29c. License number: D46992

29d. Date signed (Month, Day, Year): 5/21/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Tara T. Muscovich MD 14300 Gallant Fox La, Suite 118 Bowie, MD 20715

State Registrar

31. Date filed (Month, Day, Year): MAY 22 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16086

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Amos Atlee Ahalt
2. Dete of Deeth: Month May Day 3 Yeer 1998
3. Time of Deeth: 6:45 PM
4e. Feclity Neme (If not institution, give street end number): Frederick Memorial Hospital
4b. City, Town, or Location of Deeth: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-36-4403
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthdey): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Apr. 29, 1915
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. Stete: Md.
10b. County: Frederick
10c. City, Town or Location: Jefferson
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 3812 Jefferson Pike
10f. Zip Code: 21755
10g. Citizen of Whet Country?: U.S.A.

11. Maritel Stetus: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): farmer
16b. Kind of Business/Industry: farming

17. Father's Name (First, Middle, Last): Luther D. Ahalt
18. Mother's Neme (First, Middle, Meiden Surname): Mary Gross

19e. Informant's Name/Relationship (Type, Print): Helen M. Ahalt (Wife)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3812 Jefferson Pike, Jefferson, Md. 21755

20e. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other place): Reformed Cemetery
Dete: 5/6
20c. Locetion - City or Town, State: Jefferson, Md.

21. Signeture of Funeral Service Licensee:
22. Neme end Address of Feclity: Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. CARDIOmyopathy — 1 year
Due to (or as a consequence of):
b. Coronary Artery Disease — 8 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D 36649
29d. Date signed (Month, Dey, Yeer): 5/7/98
30. Neme end eddress of person who completed cause of death (Item 23e) (Type/Print): EDWARD P KIDD 300 4th ST. FREDERICK MD 21701

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 07 1998
32. Registrer's Signeture: Julia Davidson Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16087

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Norma R. Arrington

2. Date of Death (Month, Day, Year): May 06 1998

3. Time of Death: 4:02pm

4a. Facility Name (If not institution, give street and number): 6155 Deanna Drive

4b. City, Town, or Location of Death: Sykesville

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 219-01-8911

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 25 1920

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Sykesville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6155 Deanna Drive

10f. Zip Code: 21784

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Postal worker

16b. Kind of Business/Industry: U.S. Postal Serv.

17. Father's Name (First, Middle, Last): William B. Reeley

18. Mother's Name (First, Middle, Maiden Surname): Esther McElvaney

19a. Informant's Name/Relationship (Type, Print): Sherry Perrine (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6155 Deanna Dr. Sykesville MD 21784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem. Park

Date: 5/9/98

20c. Location - City or Town, State: Elkridge MD

21. Signature of Funeral Service Licensee: Brian L. Haight

22. Name and Address of Facility: Haight Funeral Home P.O. Box 195 Sykesville MD 21784

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Ovarian Cancer — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Nicholas Routsolakes MD

29c. License number: D38509

29d. Date signed (Month, Day, Year): May 8 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nicholas Routsolakes MD 11065 Little Patuxent Pkwy Columbia MD 21044

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAY 1 1 1998

32. Registrar's Signature: Julia Strudwick Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16088

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Arthur R. Bowser
2. Dete of Deeth — Month, Day, Year: May 5, 1998
3. Time of Deeth: 6:30 PM
4a. Facility Neme (If not institution, give street end number): 9006 Phyllis Drive
4b. City, Town, or Location of Death: Clinton
4c. County of Deeth: Prince George's

Funeral Director

5. Social Security Number: 215 26 9717
6. Sex: 1 ☐ M 2 ☐ F — X
7. Age (In yrs. lest birthday): 67 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): July 11, 1930
9. Birthplece (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10e. Stete: MD
10b. County: P.G.
10c. City, Town or Location: Clinton
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No — XX
10e. Street end Number: 9006 Phyllis Drive
10f. Zip Code: 20735
10g. Citizen of Whet Country?: United States

11. Merital Stetus: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced — X
12. Wes Decedent Ever in U.S. Armed Forces?: 1 ☒ Yes 2 ☐ No — If Yes, Give Yeer or Dates: 1951 1955
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1 ☐ Yes 2 ☐ No — XX — Specify:
14. Reca - American Indian, Black, White, etc. — Specify: White
15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 / College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Auto Glass Glazier
16b. Kind of Business/Industry: Acorn Glass Company
17. Fether's Neme (First, Middle, Last): George Bowser
18. Mother's Neme (First, Middle, Meiden Surneme): Agnes M. Yeast
19e. Informent's Neme/Reletionship (Type, Print): John A. Bowser (SON)
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 4227 Quigley Court, Waldorf, Maryland 20602
20e. Method of Disposition: XX Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Plece of Disposition (Neme of cemetery, cremetory or other plece): Maryland States Veterans Cemetery — Dete: May 11, 1998
20c. Locetion - City or Town, State: Cheltenham, Maryland
21. Signeture of Funerel Service Licensee: ▶ Charles L. Bélanger
22. Neme end Address of Feciliti: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland, 20735

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. — Approximete Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in deeth): e. Myocardial Infarction
Due to (or es e consequence of):
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in death) Lest:
b. Hypertension
Due to (or es e consequence of):
c. Diabetes
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?: 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
24e. Wes en eutopsy performed?: 1 ☐ Yes 2 ☑ No
24b. Were eutopsy findings eveileble prior to completion of cause of death?: 1 ☐ Yes 2 ☐ No
25. Wes case referred to medical exeminer?: 1 ☐ Yes 2 ☑ No
26. Plece of Deeth (Check only one): Hospitel: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)
27. Menner of Deeth: 1 ☑ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28e. Dete of Injury (Month, Dey Yeer):
28b. Time of Injury: M
28c. Injury et Work?: 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify):
28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)
29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and manner es stated. 2 ☐ **Medical Examiner:** On the besis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner stated.
29b. Signeture end title of certifier: ▶ Glenn R Edgecombe MD
29c. License number: D23826 (Md)
29d. Dete signed (Month, Dey, Yeer): 5/7/98
30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Glenn Edgecombe, M.D. 7700 Old Branch AVE Clinton, Maryland 20735

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 13 1998
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16089

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES V. BURKE

2. Data of Daath — Month: MAY Day: 10 Yaar: 1998

3. Tima of Death: 5:00 AM

4a. Facility Nama (If not institution, giva street and number): COLLINGTON LIFE CARE CENTER

4b. City, Town, or Location of Death: Mitchellville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 100-10-2118

6. Sax: 1 [X] M 2 [ ] F

7. Aga (In yrs. last birthday): 83 Yrs.

If Under 1 Yaar — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Data of Birth (Month, Day, Year): Sept. 12, 1914

9. Birthplaca (Stata or Foreign Country): Ohio

Usual Rasidanca of Decedent

10a. Stata: Maryland

10b. County: Charles

10c. City, Town or Location: White Plains

10d. Insida City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Numbar: 4370 Valley Brooke Place

10f. Zip Coda: 20695

10g. Citizan of Whet Country?: U.S.A.

11. Marital Status: 1 [ ] Navar Marriad 2 [ ] Marriad 3 [X] Widowad 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Dates:

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: White

15. Dacedant's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 12th; Collega (1-4or 5+): 6+

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): Engineer

16b. Kind of Business/Industry: U.S. Government

17. Fathar's Nama (First, Middla, Last): Edward E. Burke

18. Mothar's Nama (First, Middla, Maidan Sumama): Cecelia Forbes

19a. Informant's Name/Ralationship (Type, Print): Patrick Burke (Son)

19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code): 4370 Valley Brooke Place White Plains, MD 20695

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Place of Disposition (Nama of cematary, cramatory or othar placa): Lee Crematory Date: May 11, 1998

20c. Location - City or Town, Stata: Clinton, Maryland

21. Signature of Funaral Service Licansee: [signature]

22. Name and Addrass of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Intarval Batween Onsat and Daath

Immediata Causa (Final disaasa or condition resulting in death):
a. Cardiac arrest - approx 45 min

Dua to (or as a consequance of):
b. Cardiomyopathy > 4 years

Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or injury that initiated evants rasulting in daath) Last
Dua to (or as a consequance of):
c. Chronic Obstructive lung disease > 4 years.

Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

Osteoporosis
granulomatous disease of lungs.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [✓] No

24b. Wara autopsy findings availabla prior to complation of cause of death? 1 [ ] Yas 2 [ ] No

25. Was casa raferrad to medical examinar? 1 [ ] Yas 2 [✓] No

28. Placa of Daath (Check only ona)
Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [✓] Nursing Homa 5 [ ] Rasidanca 6 [ ] Othar (Specify)

27. Manner of Daath: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1 [✓] **Certifying Physician:** To tha bast of my knowledga, daath occurrad at the time, data and place, and dua to the causa(s) and manner as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurrad at the time, data and place, and dua to tha causa(s) and manner stated.

29b. Signatura and title of cartifiar: [signature]

29c. Licansa number: D19609

29d. Data signed (Month, Day, Yaar): 5-11-98

30. Nama and addrass of parson who completed cause of daath (Itam 23a) (Type, Print): RAMAN R. TULI, MD
3503 PERRY STREET . MOUNT RAINIER, MD. 20712

State Registrar

31. Data filed (Month, Day, Yaar): MAY 13 1998

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item #29d, Per Phy. 5/8/98, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 16090
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month / Day / Yaer	3. Tima of Death
Helen E. Bowlus	May 7 1998	4:30 AM

4a. Facility Nama (If not institution, giva straat and numbar)	4b. City, Town, or Location of Death	4c. County of Death
Care Matrix Nursing Home	Silver Spring	Montgomery

Funeral Director

5. Social Sacurity Numbar	6. Sax	7. Aga (In yrs. last birthday)	If Undar 1 Yaar: Months / Days	If Undar 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplaca (Stata or Foraign Country)
220-80-4842	1☐ M 2☒ F	88 Yrs.			Jan. 24, 1910	Maryland

Usual Rasidance of Dacadant

10a. Stata	10b. County	10c. City, Town or Location	10d. Insida City Limits
Maryland	Montgomery	Silver Spring	1☐ Yas 2☒ No

10e. Street and Numbar	10f. Zip Coda	10g. Citizan of What Country?
2700 Barker Street	20910	United States

11. Marital Status	12. Was Decedant Evar in U.S. Armed Forcas?	13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Ricen, atc.)	14. Race - Amarican Indian, Black, White, atc.
1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedant's Education (Specify only highast grada complatad)		16a. Dacedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	Collaga (1-4or 5+)		
	4 college	Teacher	Carroll County School System

17. Fathar's Nama (First, Middla, Last)	18. Mothar's Nama (First, Middla, Maidan Surnama)
William Eckard	Catherine Dell

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Strast and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda)
Helen (Jenny) Bowlus-daughter	706 Sawyer Ct. Towson, Maryland 21286

20a. Mathod of Disposition	20b. Placa of Disposition (Nama of camatery, cramatory or othar placa)	Data	20c. Location - City or Town, Stata
1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)	Pine Grove Cemetery	May 11, 1998	Mt. Airy, Maryland

21. Signatura of Funaral Sarvica Licansea: Joma B Cover

22. Nama and Addrass of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not anter tha moda of dying, such as cardiac or respiratory arrast, shock, or heart failura. List only ona causa on each line.

		Approximate Interval Batwaen Onset and Death
Immadiata Ceuse (Final disaasa or condition rasulting in death) a.	Acute myocardial syander	Sudden
Dua to (or as a consequence of):		
Saquantially list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Disaasa or injury that initiated avents rasulting in daath) Last b.		
Dua to (or as a consequanca of):		
c.		
Dua to (or as a consequanca of):		
d.		

Part II. **Other significant conditions** contributing to death but not rasulting in the undarlying causa givan in Part I.

23b. Did tobacco use contributa to the cause of daath? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad?	24b. Wara autopsy findings available prior to complation of causa of daath?
1☐ Yas 2☒ No	1☐ Yas 2☐ No

25. Was casa rafarrad to madical axaminar?	26. Placa of Daath (Check only ona)	
1☐ Yas 2☐ No	Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA	Othar: 4☒ Nursing Homa 5☐ Rasidanca 6☐ Othar (Specify)

27. Mannar of Daath	28a. Data of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurrad
1☐ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined		M	1☐ Yas 2☐ No	
	28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)			28f. Location (Street and Numbar or Rural Routa Numbar, City or Town, Stata)

29a. Cartifiar (Check only one) 1☒ **Cartifying Physician:** To tha best of my knowladga, daath occurrad at tha time, data and placa, and dua to tha causa(s) and mannar as stated.
2☐ **Medical Examinar:** On the basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of cartifiar	29c. Licansa number	29d. Data Signed (Month, Day, Yaar)
Myron L. Lenkan	D0667 4	~~6/7/98~~ 5/7/98

30. Nama and addrass of parson who completed cause of daath (Itam 23a) (Type, Print): MYRON L. LENKAN MD 2309 SHOREFIELD RD WHEATON MD. 20902

State Registrar

31. Data filed (Month, Day, Yaar)	32. Registrar's Signatura
MAY 08 1998	Julie Strudwick Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16091

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ethel Vallee Barbe

2. Date of Death Month Day Year: May 10, 1998

3. Time of Death: 12:40 p.m.

4a. Facility Name *(If not institution, give street and number)*: Moran Manor Nursing Home

4b. City, Town, or Location of Death: Westernport

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 236-16-1596

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 24,1911

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: WV

10b. County: Mineral

10c. City, Town or Location: Keyser

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 12 North Main Street

10f. Zip Code: 26726

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Charles Jackson

18. Mother's Name *(First, Middle, Maiden Surname)*: Katherine Ashby

19a. Informant's Name/Relationship *(Type, Print)*: Charles D. Barbe (Son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: HC72 Box 144, New Creek, WV 26743

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Potomac Mem. Gardens Date: 5/13/98

20c. Location - City or Town, State: Keyser, WV

21. Signature of Funeral Service Licensee: Harold Dean Mossinger

22. Name and Address of Facility: Markwood McKenzie Funeral Home 111 S. Mineral St, Keyser, WV 26726

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Glioblastoma Right Occipital Area — 5 Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D21244

29d. Date signed *(Month, Day, Year)*: 5/12/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Jesus H. Tan, M.D., Frostburg Plaza, Frostburg, Maryland 21532

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

2 NDS

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 14 1998

32. Registrar's Signature

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16092

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret Ruth Carney

2. Date of Death Month Day Year: May 10, 1998

3. Time of Death: 4:10 PM

4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 261-12-9778

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 3, 1920

9. Birthplace *(State or Foreign Country)*: Florida

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Clarksburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 24101 Clarksburg Road

10f. Zip Code: 20871

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Manager

16b. Kind of Business/Industry: U.S. Government

17. Father's Name *(First, Middle, Last)*: Brewer Calloway Peddy

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Ellen McKain

19a. Informant's Name/Relationship *(Type, Print)*: Maureen L. Carney - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 24101 Clarksburg Road, Clarksburg, Maryland 20871

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arlington National Cemetery

Date: 5/19/98

20c. Location - City or Town, State: Ft. Meyer, Virginia

21. Signature of Funeral Service Licensee: ▶ Robert L. Williams

22. Name and Address of Facility: Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. shock — 1 hour

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ruptured abdominal aortic aneurism — years

Due to (or as a consequence of):

c. atherosclerotic cardiovascular disease — years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: ▶ Steven H. Dolinsky MD

29c. License number: 20148-D

29d. Date signed *(Month, Day, Year)*: 11 May 98

30. Name and address of person who completed cause of death (Item 29a) (Type, Print): Steven H. Dolinsky MD 4-6 Executive Park Court, Germantown, Maryland 20874

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 12 1998

32. Registrar's Signature: ▶ Julia Davidson Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16093

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Cox

2. Date of Death: Month May Day 9 Year 1998

3. Time of Death: 6:45pm

4a. Facility Name (If not institution, give street and number): Rockville Nursing Home

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 022-09-1848

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 12,1917

9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1482 Selworthy Road

10f. Zip Code: 20854

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Senior Clerk

16b. Kind of Business/Industry: Research

17. Father's Name (First, Middle, Last): John Rock

18. Mother's Name (First, Middle, Maiden Surname): Nasta Blonish

19a. Informant's Name/Relationship (Type, Print): Arthur Cox/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13702 Hillside Avenue, Thurmont, Maryland 21788

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium Inc.

Date: 5/10

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Todd D Wynn

22. Name and Address of Facility: Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myelodysplastic Syndrome Six months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

Psoriatic arthritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [illegible] MD

29c. License number: 031839

29d. Date signed (Month, Day, Year): May 9, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christopher C. Dunford M.D. 615 West Montgomery Ave. Rockville, MD 20850

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAY 11 1998

32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

98-2655-017
B.K.S
ROBERT MICHAEL COBEY JR.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16094

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT MICHAEL COBEY JR.
2. Date of Death (Month, Day, Year): MAY 10, 1998
3. Time of Death: 11:45 AM
4a. Facility Name (If not institution, give street and number): 6794 FORT TOBACCO ROAD
4b. City, Town, or Location of Death: INDIAN HEAD
4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 219-21-3911
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 17 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 17, 1980
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CHARLES
10c. City, Town or Location: INDIAN HEAD
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5939 PORT TOBACCO ROAD
10f. Zip Code: 20640
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): STUDENT
16b. Kind of Business/Industry: EDUCATION

17. Father's Name (First, Middle, Last): ROBERT M. COBEY SR.
18. Mother's Name (First, Middle, Maiden Surname): SHERA ANN BUTLER COBEY

19a. Informant's Name/Relationship (Type, Print): SHERA COBEY / MOTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5939 PORT TOBACCO ROAD, INDIAN HEAD, MD 20640

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FOREST HILLS MEMORIAL CEM — Date: 5/15/98
20c. Location - City or Town, State: CLINTON, MARYLAND

21. Signature of Funeral Service Licensee: LYDIA C. THORNTON JOHNSON
22. Name and Address of Facility: THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD INDIAN HEAD, MD 20640

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. Multiple Injuries
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) AT SCENE

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year): 5/10/98
28b. Time of Injury: 1118 HRS PM
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Struck by truck
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): roadway
28f. Location (Street and Number or Rural Route Number, City or Town, State): 6794 Ft Tobacco Road Indian Head Maryland

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. Kingsbury
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): MAY 11, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. KINGSBURY 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 13 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16095

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Herta Wilson Cavenaugh

2. Date of Death: Month May Day 11, Year 1998

3. Time of Death: 9:03AM

4a. Facility Name (If not institution, give street and number): Civista Medical Center

4b. City, Town, or Location of Death: La Plata

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 212-46-8532

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG. 8-13-1906

9. Birthplace (State or Foreign Country): Pelham, NY

Usual Residence of Decedent

10a. State: MD

10b. County: Charles

10c. City, Town or Location: La Plata

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 10200 La Plata Rd.

10f. Zip Code: 20646

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Journalist

16b. Kind of Business/Industry: Newspaper

17. Father's Name (First, Middle, Last): Francis Asbury Wilson

18. Mother's Name (First, Middle, Maiden Surname): Emily Newcomb Wilson

19a. Informant's Name/Relationship (Type, Print): Cynthia Shoemaker/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5150 Marbury Run Rd. Marbury, MD. 20658

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: [signature] mo08:7

22. Name and Address of Facility: Arehart-Echols Funeral Home P.A. P.O. Box 567 La Plata, Md. 20646

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Pulmonary Embolism

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Atrial fibrillation

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary hypertension, Myocardial Infarct Defibrination Syndrome, Right Ventricular failure

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): 05/11/98

28b. Time of Injury: 905 AM

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Natural

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOSPITAL

28f. Location (Street and Number or Rural Route Number, City or Town, State): 701 East Charle Street La Plata Maryland

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Michael A. Pimentel, DO

29c. License number: H42445

29d. Date signed (Month, Day, Year): 05/11/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Pimentel, DO 601 Post Office Road, Suite 1-A, Waldorf, Maryland 20602

State Registrar

31. Date filed (Month, Day, Year): MAY 13 1998

32. Registrar's Signature: [signature] Julia Davidson Randall

To Be Completed by Funeral Director

Herta W. Cavenaugh
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16096

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Wayne Samuel Creadick, Sr.

2. Dete of Death Month / Day / Yeer: May 3, 1998

3. Time of Deeth: 8:20 PM

4a. Facility Neme (If not Institution, giva street end number): 7105 Victoria Place

4b. City, Town, or Location of Deeth: Upper Marlboro

4c. County of Deeth: Prince George's

Funeral Director

5. Sociel Security Number: 222-22-2676

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthdey): 61 Yrs.

If Undar 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Year): August 19,1936

9. Birthpleca (Steta or Foreign Country): Delaware

Usual Residence of Decedent

10e. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7105 Victoria Place

10f. Zip Code: 20772

10g. Citizen of What Country?: U.S.A.

11. Marltal Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Detas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Maxican, Puarto Rican, etc.): 1 [ ] Yes [X] No Specify:

14. Raca - Amarican Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest greda completed): Elamantary/Secondary (0-12): 12; College (1-4or 5+): 3

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Insurance Agent

16b. Kind of Business/Industry: Self-Employed Insurance Company

17. Fethar's Name (First, Middle, Last): Leland Samuel Creadick

18. Mother's Neme (First, Middle, Maidan Surname): Iva K. Kent

19e. Informant's Name/Raletionship (Type, Print): Edna Creadick (Wife)

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7105 Victoria Place Upper Marlboro, Maryland 20772

20e. Method of Disposition: [X] 1 Buriel 2 [ ] Cremetion 3 [ ] Removal trom State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cametery, cremetory or other piece): Dwaryers Cemetery

Dete: May 7,1998

20c. Location - City or Town, Stete: Odessa, DE

21. Signeture of Funeral Service Licensee

22. Nema and Address of Feciliity: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode ot dying, such es cardiec or respiratory arrest, shock, or heart feilure. List only one cause on eech lina.

Approximete Intarvel Batween Onset end Deeth

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC RENAL CELL CANCER — 15 mos

Due to (or as a consequenca of):

Sequantially list conditions, if eny, leading to immedieta cause. Enter Underlying Cause (Diseesa or injury thet initiatad events resulting in deeth) Last:

b. Due to (or as e consequenca of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in tha underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yas 2 [X] No

24b. Were autopsy tindings aveileble prior to completion of causa of deeth? N/A 1 [ ] Yes 2 [ ] No

25. Wes casa referred to medical examiner? 1 [ ] Yas 2 [ ] No

26. Piace of Deeth (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Othar (Specify)

27. Manner of Deeth: 1 [ ] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Deta ot Injury (Month, Dey Year)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Dascribe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Spacify)

28t. Location (Street end Number or Rural Route Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner es steted. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, daeth occurred et tha tima, data and piaca, end due to tha cause(s) end menner steted.

29b. Signature end title ot certifier: Stephen Staal MD

29c. License number: D18219

29d. Date signed (Month, Day, Year): 5/4/98

30. Nema end eddress of person who completed causa of daath (item 23a) (Type, Print): Steven Staal M.D. 1221 Mercantile Lane Largo, Md 20774

State Registrar

31. Dete tiled (Month, Dey, Year): MAY 13 1998

32. Registrar's Signatura: John Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16097

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bertha Louise Compton
2. Date of Death (Month, Day, Year): May 5 1998
3. Time of Death: 4:45 AM
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-20-4191
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 6, 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Rocky Ridge
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9829 Rocky Ridge Rd.
10f. Zip Code: 21778
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Operator
16b. Kind of Business/Industry: Grocery Store

17. Father's Name (First, Middle, Last): Carroll Reese
18. Mother's Name (First, Middle, Maiden Surname): Bertha Gartrell

19a. Informant's Name/Relationship (Type, Print): Stanley J. Compton - Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9829 Rocky Ridge Rd. Rocky Ridge, Md. 21778

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Resthaven Mem Gardens
Date: 1998 May 8,
20c. Location - City or Town, State: Frederick, Md.

21. Signature of Funeral Service Licensee: Catharine O. VanKirk
22. Name and Address of Facility: Hartzler Funeral Home 404 S. Main St. Woodsboro, Md. 21798

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Emphysema	Years
Due to (or as a consequence of):	b. COPD Pulmonale	Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M Tolino MD
29c. License number: MD0051610
29d. Date signed (Month, Day, Year): 5-5-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Tolino 1475 Taney Ave, Suite 204, Frederick, MD 21701

State Registrar

31. Date filed (Month, Day, Year): MAY 11 1998
32. Registrar's Signature: Judy Thurlow-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16098

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Howard R. Cecil Sr.

2. Date of Death — Month: MAY; Day: 12; Year: 1998

3. Time of Death: 0055

4e. Facility Name *(If not institution, give street and number)*: Sacred Heart Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 216-22-6013

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov 9, 1927

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cresaptown

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 14216 Winchester Road

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Former Employee

16b. Kind of Business/Industry: Textile

17. Father's Name *(First, Middle, Last)*: Bernard E. Cecil

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary V. (Hite)

19a. Informant's Name/Relationship *(Type, Print)*: Betty L. Cecil-Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14216 Winchester Road Cresaptown MD 21502

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rocky Gap Veterans Cem — Date: 05/15

20c. Location - City or Town, State: Flintstone MD

21. Signature of Funeral Service Licensee: ▶ James F Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac failure	1 wk.
Due to (or as a consequence of):	b. arteriosclerotic Heart Disease	20 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Rheumatoid arthritis

Emphysema

Chronic cystitis

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)* — Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)* — 1 ☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ George Breza MD

29c. License number: D12532

29d. Date signed *(Month, Day, Year)*: MAY 18 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George Breza M.D. 912 Seton Drive Cumberland MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 18 1998

32. Registrar's Signature: ▶

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Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

233 68 1527 CROCK, SAMUEL SHAFFER FUNERAL HOME/ROMNEY 0927 HRS DR BASHARMAL?VET ADM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 16099
Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SAMUEL EDWARD CROCK
2. Date of Death — Month: MAY; Day: 6; Year: 1998
3. Time of Death: 9:27 A.M.
4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital & Medical Center
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 233-68-1527
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 54 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 11, 1943
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: WV
10b. County: Hampshire
10c. City, Town or Location: Springfield
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: P. O. Box 78
10f. Zip Code: 26763
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1960 1961
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Electrician
16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Lest)*: Edward Branson Crock
18. Mother's Name *(First, Middle, Meiden Surname)*: Alice Virginia Mullin

19a. Informent's Neme/Relationship *(Type, Print)*: Patsy J. Crock Wife
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: P. O. Box 78, Springfield, WV 26763

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Springfield Hill Cemetery — Dete: May 8 1998
20c. Location - City or Town, Stata: Springfield, WV

21. Signature of Funeral Service Licensee: ▶ Mark Shaffer
22. Name and Address of Facility: Shaffer Funeral Home, Inc. 230 East Main St., Romney, WV 26757

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6 yrs

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiopulmonary arrest — immediate
Due to (or as a consequence of):
b. Acute Myocardial infarction — hours
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Atherosclerotic cardiovascular disease — years
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as steted. 2 [ ] **Medical Examiner:** On the besis of examination end/or investigetion, in my opinion, death occurred at the time, date and piace, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ K. Basharmal
29c. License number: 35 0660-72 B
29d. Data signed *(Month, Day, Year)*: 5 18 98

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): Khodaidad K. Basharmal MD 710 Memorial Ave. Cumberland, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Deta filed *(Month, Day, Year)*: MAY 12 1998
32. Registrar's Signature

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16100

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Thomas Ronald Dashiell

2. Deta of Death: Month May; Dey 3; Year 1998

3. Time of Death: 11:59 PM

4e. Facility Nama *(If not institution, give street end number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Deeth: Frederick

Funeral Director

5. Social Security Numbar: 218-20-9838

6. Sex: 1☒M 2☐F

7. Age *(In yrs. lest birthday)*: 70 Yrs.

If Under 1 Yaar: Months; Deys

If Under 24 Hrs.: Hours; Min.

8. Date of Birth *(Month, Dey, Year)*: Sept. 9, 1927

9. Birthplece *(Stete or Foreign Country)*: Maryland

Usuel Residence of Dacedent

10e. Stete: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street end Number: 504 Thomas Avenue

10f. Zip Code: 21701

10g. Citizen of What Country?: United States

11. Meritel Status: 1☐Nevar Merried 2☒Married 3☐Widowed 4☐Divorcad

12. Was Decedent Evar in U.S. Armed Forcas? 1☒Yas 2☐No If Yas, Give Yeer or Datas: 1946 1947

13. Was Decedent of Hispanic Origin? (Specify Yas or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yas 2☒No *Specify:*

14. Reca - Amarican Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grada completed)*: Elemantary/Secondary (0-12): 12; College (1-4or 5+): 5+

16e. Decedent's Usuel Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Chemical Engineer Consultant

16b. Kind of Business/Industry: US Gov't

17. Father's Nema *(First, Middla, Last)*: Elmer Thomas Dashiell

18. Mother's Name *(First, Middle, Meiden Surnema)*: Dortha Lee English

19e. Informant's Name/Relationship *(Type, Print)*: Virginia Trout Dashiell / wife

19b. Meiling Addrass *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 504 Thomas Ave., Frederick, Maryland 21701

20a. Method of Disposition: 1☒Burial 2☐Cramation 3☐Removal from Steta 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Nama of cemetery, cremetory or othar place)*: Mt. Olivet Cemetery

Data: 5/8/98

20c. Location - City or Town, Stete: Frederick, Maryland

21. Signeture of Funaral Service Licensee: Raymond Peterson

22. Nama and Address of Facility: Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter tha disease, or complicetions thet caused the deeth. Do not antar tha mode of dying, such es cardiec or raspiratory arrast, shock, or haart failure. List only one ceuse on aech line.

Approximate Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in daath)

e. Acute myelogenous leukemia — 6 m.

Dua to (or as a consequence of):

Sequentielly iist conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest

b. myelodysplastic Syndrome — 4 years

Dua to (or es e consequence of):

c.

Due to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24e. Wes en eutopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings eveilebla prior to completion ot cause of death? 1☐Yas 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☑Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Othar *(Specify)*

27. Manner of Deeth: 1☑Naturel 2☐Accident 3☐Sulcide 4☐Homicida 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At homa, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Steta)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician:** To tha best of my knowledge, deeth occurred at tha time, date and piece, and due to the cause(s) and manner as stated. 2☐**Medical Exeminer:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, deta end piace, and dua to the cause(s) and manner steted.

29b. Signature end title of certifier: MD

29c. License number: D 48184

29d. Dete signed *(Month, Dey, Year)*: May 4, 1998

30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print): Elhamy Eskander, 501 W. 7th Street / Frederick, Maryland 21701

State Registrar

31. Data filed *(Month, Dey, Yeer)*: MAY 07 1998

32. Registrar's Signeture: Julia Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16101

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ellen Virginia Davis

2. Date of Death (Month, Day, Year): May 5, 1998

3. Time of Death: 7:30 AM

4a. Facility Name (If not institution, give street and number): 8700 Creekway Drive

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 095 22 0694

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec 16, 1929

9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. Stete: MD

10b. County: Prince George's

10c. City, Town or Location: Clinton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 8700 Creekway Drive

10f. Zip Code: 20735

10g. Citizen of What Country? United States

11. Maritel Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorcad

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 2

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Columbia Law School

17. Father's Name (First, Middle, Last): Addison Laws

18. Mother'a Name (First, Middle, Maiden Surname): Flora Jenkins

19a. Informant's Name/Reletionshlp (Type, Print): Timothy A. Davis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8700 Creekway Drive, Clinton,Maryland 20735

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Name of cemetery, crematory or other place): May 6, 1998 Lee Crematory

Date

20c. Location - City or Town, Stete: Clinton,Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Facility: Lee Funeral Home,Inc 6633 Old Alexandria Ferry Road, Clinton,Maryland 20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death) e.	PROGRESSIVE DEMENTIA	7 Months
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	END- STAGE RENAL DISEASE	7 Months
Due to (or as e consequence of):		
c.	CHRONIC HEMODIABESIS	7 Months
Due to (or as a consequence of):		
d.	MYOCARDIAL INFARCTIONS	2 Months

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES METLITUS

HYPERTENSION

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

28. Place of Deeth (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date end plece, end due to the cause(s) and menner steted.

29b. Signature end title of certifier: [signature] M D

29c. License number: D43772

29d. Date signed (Month, Day, Year): 05/05/98

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Rasaq Abu, M.D. 7501 Surratts Road # 208 B, Clinton,Maryland 20735

State Registrar

31. Date filed (Month, Day, Year): MAY 13 1998

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16102

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: KENNETH RICHARD DOLLY SR.

2. Date of Death Month / Day / Year: MAY 12 1998

3. Time of Death: 1:00 PM

4a. Facility Name *(If not institution, give street and number)*: 13015 BLUEGRASS DRIVE

4b. City, Town, or Location of Death: FLINTSTONE

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 216-22-6915

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MARCH 18 1928

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: FLINTSTONE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13015 BLUEGRASS DRIVE

10f. Zip Code: 21530

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW11

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: OWNER/OPERATOR DOLLY TRUCKING

16b. Kind of Business/Industry: TRUCKING

17. Father's Name *(First, Middle, Last)*: DAYTON DEXTER DOLLY

18. Mother's Name *(First, Middle, Maiden Surname)*: VERDA MARIE ALT

19a. Informant's Name/Relationship *(Type, Print)*: MARY ANN DOLLY WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13015 BLUEGRASS DRIVE FLINTSTONE MARYLAND 21530

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GLENDALE CEMETERY

Data: MAY 15 1998

20c. Location - City or Town, State: FLINTSTONE MARYLAND

21. Signature of Funeral Service Licensee: Dale L. Merritt

22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. RESPIRATORY FAILURE	ONE DAY
	Due to (or as a consequence of):	
	b. METASTATIC LUNG CANCER	THREE YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D 33417

29d. Date signed *(Month, Day, Year)*: MAY 13 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. JAMES MOEN 1068 NATIONAL HIGHWAY LAVALE, MARYLAND 21502

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 13 1998

32. Registrar's Signature:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16103

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edward Willard Dell

2. Date of Death Month Day Year: MAY 9, 1998

3. Time of Death: 1203 PM

4a. Facility Name *(If not institution, give street and number)*: Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 213-16-1318

6. Sex: 1 ☑ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 16, 1920

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Manchester

10d. Inside City Limits: 1 ☐ Yes 2 ☑ No

10e. Street and Number: 2300 Ebbvale Road

10f. Zip Code: 21102

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: farmer

16b. Kind of Business/Industry: Dairy

17. Father's Name *(First, Middle, Last)*: Edward Roger Dell

18. Mother's Name *(First, Middle, Maiden Surname)*: Elsie Viola Parrish

19a. Informant's Name/Relationship *(Type, Print)*: Catherine Irene Dell, wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2300 Ebbvale Road, Manchester, MD 21102

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Pleasant Cemetery

Date: 05/13/98

20c. Location - City or Town, State: Gamber, MD

21. Signature of Funeral Service Licensee: Katherine Pritts - Switzer

22. Name and Address of Facility: Pritts Funeral Home & Chapel, 412 Washington Rd., Westminster, MD 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. INTESTINAL INFARCTON.

Due to (or as a consequence of):
b. ATHEROSCLEROSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

1. RIGHT BRAIN STROKE.
2. MYOCARDIAL INFARCTION
3. EMPHYSEMA

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: N. Rajpara

29c. License number: D 29264

29d. Date signed *(Month, Day, Year)*: MAY 9, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): N. RAJPARA . 217 - WASHINGTON MD - WESTMINSTER MD 21157

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 11 1998

32. Registrar's Signature: Judith Hudson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

[illegible] UNIT # 07-52-78
[illegible] EDWARD WILLARD
CCU-06 [illegible] RAJPARA, MATVARLAL K
05/16/1920 M 05/04/98
IHP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16104

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lidia Marie Fowlkes

2. Date of Death (Month, Day, Year): May 10, 1998

3. Time of Death: 8:35 AM

4a. Facility Name (If not institution, give street and number): Haven Home

4b. City, Town, or Location of Death: Mt. Airy

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-12-6250

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 1, 1916

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Wheaton

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 11701 Galt Ave.

10f. Zip Code: 20902

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): self

16b. Kind of Business/Industry: homemaker

17. Father's Name (First, Middle, Last): Pasquale Barcarola

18. Mother's Name (First, Middle, Maiden Surname): Barbara Pelandrandea

19a. Informant's Name/Relationship (Type, Print): Sharon Willingham, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7211 Honeybush Dr., Mt. Airy, MD 21771

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Prospect Church Cemetery | Date: 5/11/98

20c. Location - City or Town, State: Mt. Airy, Maryland

21. Signature of Funeral Service Licensee: Ryan M. Burgess

22. Name and Address of Facility: Stauffer Funeral Home, 1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Anemia — 3 mos

Due to (or as a consequence of):
b. mesothelioma of lung — 8 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Demented (ALZHEIMERS)

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David B Hardage, MD

29c. License number: D35965

29d. Date signed (Month, Day, Year): 5/11/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID B. HARDAGE MD 602 CENTER ST. #209 MT. AIRY, MD 21771

State Registrar

31. Date filed (Month, Day, Year): MAY 12 1998 JUN 23 1998

32. Registrar's Signature: Julia Davidson Radcliffe

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16105

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HARRY LEON FULMER
2. Date of Death Month / Day / Year: MAY 3, 1998
3. Time of Death: 8:30 AM
4a. Facility Name *(If not institution, give street and number)*: 4541 Cherry Lane
4b. City, Town, or Location of Death: Jefferson
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-10-3572
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 25, 1914
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10e. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5125 Old National Pike
10f. Zip Code: 21702
10g. Citizen of What Country?: United States
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944 - 1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Postal Clerk
16b. Kind of Business/Industry: US Mail
17. Father's Name *(First, Middle, Last)*: Lewis N. Fulmer
18. Mother's Name *(First, Middle, Maiden Surname)*: Esta Baer
19a. Informant's Name/Relationship *(Type, Print)*: William L. Fulmer / son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 27, Braddock Heights, MD 21714
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Lutheran Cemetery
Date: 5/6/98
20c. Location - City or Town, State: Middletown, Maryland
21. Signature of Funeral Service Licensee: ▶ Robert B. Mackley
22. Name and Address of Facility: Stauffer Funeral Home, 1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. STROKE — 3 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Neil Wasserman MD
29c. Licensa number: D47611
29d. Date signed *(Month, Day, Year)*: 5/4/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NEIL WASSERMAN MD 1475 TANEY AVE FREDERICK MD 21702

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 05 1998
32. Registrar's Signature: Julie Davidson Radcliff

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16106

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: MARIE ELLEN FENDER
2. Dete of Death Month: May Dey: 3, Year: 1998
3. Time of Deeth: 10:26 AM
4a. Facility Neme *(If not institution, give street end number)*: Frederick Health Care Center
4b. City, Town, or Location of Death: Frederick
4c. County of Deeth: Frederick

Funeral Director

5. Social Security Number: 220-38-1503
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. lest birthday)*: 79 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: Oct. 12, 1918
9. Birthplece *(Stete or Foreign Country)*: Virginia

Usual Residence of Decedent

10e. Stete: Maryland
10b. County: Frederick
10c. City, Town or Location: Knoxville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 4024 Petersville Road
10f. Zip Code: 21758
10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1☐ Never Merriad 2☒ Merried 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Bleck, Whita, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mail Clerk
16b. Kind of Business/Industry: Post Office

17. Father's Name *(First, Middle, Last)*: William A. Riely
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Etta Florence Steward

19e. Informent's Neme/Relationship *(Type, Print)*: Jerry A. Fender (Son)
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 1113 Cherry Point Road, West River, MD 20778

20e. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Remaval from State 4☐ Donation 5☒ Othar *(Specify)* Entombment
20b. Piece of Disposition *(Neme of cemetery, cremetory or othar place)*: Resthaven Mem. Gardens — Date: 5/7/98
20c. Location - City or Town, Stata: Frederick, Maryland

21. Signeture of Funeral Service Licensee: Robert E. Dailey Jr
22. Nama and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat end Deeth

Immediate Ceuse (Final disease or condition resulting in death): e. Chronic obstructive pulmonary disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initieted events rasulting in deeth) Lest:
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Recent pelvic surgery, peripheral vascular disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings availeble prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowladge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at tha time, data end place, and due to tha ceuse(s) and menner steted.

29b. Signeture end title of certifier: Kathleen W Stern MD
29c. Licensa number: D32073
29d. Date signed *(Month, Dey, Year)*: May 6, 1998

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Kathleen W. Stern MD, 4014 Mountville Road, Jefferson, Maryland 21755

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 06 1998
32. Registrer's Signeture: Gale Davidson Parker

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the deeth certificete be executed within 24 hours after deeth.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16107

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Justin Michael Fortenberry
2. Date of Death Month/Day/Year: 04/30/98
3. Time of Death: 1710
4a. Facility Name (If not institution, give street and number): Antietam Creek
4b. City, Town or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 601-48-3783
6. Sex: X 1 M 2 F
7. Age (In yrs. last birthday): 23 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 18, 1974
9. Birthplace (State or Foreign Country): California

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 X Yes 2 No
10e. Street and Number: 1309 Pinewood Drive
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 Never Married 2 Married 3 Widowed 4 X Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Craftsman
16b. Kind of Business/Industry: Restoration Company

17. Father's Name (First, Middle, Last): Terry Ray Fortenberry Sr.
18. Mother's Name (First, Middle, Maiden Surname): Merilyn May Fortenberry

19a. Informant's Name/Relationship (Type, Print): Merilyn M. Fortenberry (Mother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 911 West Calle Casiquilla, Tucson, AZ 85704

20a. Method of Disposition: 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory
Date: 5/8/98
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey Jr
22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Drowning — Due to (or as a consequence of): — minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 X Yes 2 No

26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA — Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Creek.

27. Manner of Death: 1 Natural 2 X Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day, Year): 04/30/98
28b. Time of Injury: 1710 M
28c. Injury at Work? 1 Yes 2 X No
28d. Describe how injury occurred: Fell into creek
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Antietam Creek
28f. Location (Street and Number or Rural Route Number, City or Town, State): Hagerstown MD

29a. Certifier (Check only one): 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D26806
29d. Date signed (Month, Day, Year): 05/07/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Alan D. Howe 742 Dorsey Ave Hagerstown MD 21742

State Registrar

31. Date filed (Month, Day, Year): MAY 11 1998
32. Registrar's Signature: John Theodore Rudelli

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16108

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOSEPH FUSCO SR

2. Date of Death Month / Dey / Year: MAY 10 1998

3. Time of Death: 7:33 PM

4a. Facility Name *(If not institution, give street and number)*: CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death: LA PLATA

4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 717-12-2899

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthdey)*: 79 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Houre / Min.

8. Date of Birth *(Month, Dey, Year)*: FEB 5 1919

9. Birthplece *(State or Foreign Country)*: Pennsylvania

Usuel Residence of Decedent

10a. State: Maryland | 10b. County: Prince George's | 10c. City, Town or Location: Brandywine | 10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6208 Church Drive | 10f. Zip Code: 20613 | 10g. Citizen of What Country?: USA

11. Meritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: X

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - Americen Indian, Black, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: US Armed Forces

16b. Kind of Business/Industry: National Security

17. Father's Name *(First, Middle, Last)*: Vincent Fusco

18. Mother'e Name *(First, Middle, Maiden Sumeme)*: Theresa Vella Fusco

19a. Informant's Name/Relietionship *(Type, Print)*: Dorothy Louise Fusco (Wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6208 Church Dr. Brandywine, MD 20613

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, crematory or other piece)*: Maryland Veterans Cem. | Dete: 5-15-98

20c. Locetion - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: John A Eberwein M00173

22. Name and Address of Facility: J.H. Eberwein Mortuary 4433 White Pls La White Pls., MD 20695

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Final disease or condition rasulting in death): a. Coronary artery disease — 19 yr.

Due to (or as a consequance of): b. Ischemic cardiomyopathy

Sequentielly list conditions, if eny, leeding to Immediate causa. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last:

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying ceuse givan in Part I.: Hyperlipidemia

23b. **Did tobacco uee contribute to the cause of death?** 1 [ ] Yee 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medicel exeminer? 1 [ ] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [✓] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Data of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury st Work? 1 [ ] Yes 2 [ ] No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician**: To the best of *my* knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examinar**: On the basis of examination and/or investigation, In *my* opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: John C Patterson MD | 29c. License number: D19633 | 29d. Date signed *(Month, Day, Year)*: 5/11/98

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): John C. Patterson, M.D., 7501 Surratts Rd #201A Clinton Md 20735

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 13 1998

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16109

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELENA MAE FOEHRKOLB

2. Date of Death: Month 5 Day 13 Year 98

3. Time of Death: 7:15 PM

4a. Facility Name (If not institution, give street and number): Chesapeake Rehabilitation Hospital

4b. City, Town, or Location of Death: Salisbury

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 554-28-2591

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2/17/18

9. Birthplace (State or Foreign Country): PA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Berlin

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11003 Grays Corner RD

10f. Zip Code: 21811

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeping Supervisor

16b. Kind of Business/Industry: College

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Maiden Surname): Edna Jerico

19a. Informant's Name/Relationship (Type, Print): James William Young/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2819 Plover Dr. Unit 41 Ocean City, MD 21842

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cape Henlopen Crematory

Date: 5/16/98

20c. Location - City or Town, State: Frankford, DE

21. Signature of Funeral Service Licensee: W. Burbage

22. Name and Address of Facility: Burbage Funeral Home 108 William St. Berlin, MD 21811

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident (Recurrent) — 2 months

Due to (or as a consequence of):

b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Atrial Fibrillation

Due to (or as a consequence of):

d. Hypertension

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Chesapeake Rehab. Hospital

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jeffrey W. Anderson

29c. License number: H45955

29d. Date signed (Month, Day, Year): 05-13-98

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Jeffrey Anderson D.O. 100 E. Carroll St. PRMC Salisbury, MD 21801

State Registrar

31. Date filed (Month, Day, Year): MAY 15 1998

32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16110

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Emma Frances HEFLIN
2. Deta of Death: Month May Day 6, Yaar 1998
3. Time of Death: 5:30 A.M.
4a. Feciility Name (If not institution, give street end number): Glade Valley Nursing Center
4b. City, Town, or Location of Deeth: Walkersville
4c. County of Deeth: Frederick

Funeral Director

5. Social Security Number: 427-24-7073
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Dey, Yeer): Aug. 8, 1923
9. Birthplece (Stete or Foreign Country): Mississippi

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: Frederick
10c. City, Town or Location: Walkersville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 56 West Frederick Street
10f. Zip Code: 21793
10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Detas:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - Amarican Indian, Bieck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Federal Government

17. Fathar's Neme (First, Middle, Last): George Washington FIKES
18. Mother's Name (First, Middle, Maiden Surneme): Margaret NEW

19a. Informent's Name/Relationship (Type, Print): Ronald C. Heflin, Son
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 7907 Hope Valley Court, Adamstown, MD 21710

20e. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Smithsburg Crematory, May
Date: 7, 1998
20c. Location - City or Town, Stete: Smithsburg, Maryland

21. Signeture of Funarel Service Licensee: ▶ Allan H Ruby MO0703
22. Neme end Address of Facility: Keeney and Basford PA Funeral Home 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complicetions that caused the death. Do not antar the moda of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one ceuse on each line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth)
e. Ventricular Fibrillation — minutes

Due to (or es e consequence of):
b. Atherosclerotic Cardiovascular Dis — >5 years

Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying ceuse given in Pert I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medicel exeminer? 1☐ Yes 2☒ No
26. Piece of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Sulcida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physicien**: To the best of my knowledge, deeth occurred et the time, date and piece, end due to the ceuse(s) end manner es stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete and placa, and dua to the ceuse(s) end manner steted.

29b. Signeture and title of certifier: ▶ Allen J. Gilson
29c. License number: D 26515
29d. Dete signed (Month, Day, Year): May 6, 1998

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): Allen J. Gilson MD 1475 Taney Avenue, Frederick, Maryland 21702

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 07 1998
32. Registrer's Signeture: Elsie Davidson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'naturel', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

98 16111

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Norman	Wilson	Hudson	May 7, 1998	2:45 AM M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
578 26 4492	1 [X] M 2 [ ] F	72 YRS.			June 14, 1925	Washington DC

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
3407 Randall Road	Suitland	Prince George's

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	Prince George's	Suitland	1 [ ] YES 2 [XX] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
3407 Randall Road	20746	United States

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	[XX] YES 2 [ ] NO	1 [ ] YES 2 [X] NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		Truck Driver	TBN

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Archibald W. Hudson	Almeda Grimes

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joanne Bennett	10505 Cedarville Road, Lot 3-9- Brandywine, Md 20613

20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)	DATE	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Cedar Hill Cemetery	May 11, 98	Suitland, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ [signature]	Lee Funeral Home,Inc 6633 Old Alexandria Ferry Road, Clinton,Md 20735

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Malignant Mesothelioma
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastitic Cancer

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [ ] NO X	1 [ ] YES [XX] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES [XX] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [XX] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [XX] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D19307	▶ May 7, 1998

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Herbert Friedman, M.D. 110 Irving Street, N.W.Washington, DC 20010

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAY 13 1998	[signature]

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16112

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elmer J. Henaghan

2. Date of Death — Month: MAY Day: 13 Year: 1998

3. Time of Death: 10:59 AM

4a. Facility Name *(If not institution, give street and number)*: Sacred Heart Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 217-14-4356

6. Sex: [X] 1 M [ ] 2 F

7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec 28, 1921

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: WV

10b. County: Mineral

10c. City, Town or Location: Ridgeley

10d. Inside City Limits: [ ] 1 Yes [X] 2 No

10e. Street and Number: Route 1 Box 47

10f. Zip Code: 26753

10g. Citizen of What Country?: USA

11. Marital Status: [ ] 1 Never Married [X] 2 Married [ ] 3 Widowed [ ] 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? [X] 1 Yes [ ] 2 No — If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) [ ] 1 Yes [X] 2 No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Maintenance Mechanic

16b. Kind of Business/Industry: Allegany Ballistics Lab

17. Father's Name *(First, Middle, Last)*: John Henaghan

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Anna (Wilderman)

19a. Informant's Name/Relationship *(Type, Print)*: M. Doris Henaghan--wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Route 1 Box 47 Ridgeley, WV 26753

20a. Method of Disposition: [X] 1 Burial [ ] 2 Cremation [ ] 3 Removal from State [ ] 4 Donation [ ] 5 Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rocky Gap Veterans Cemetery — Date: 5/15

20c. Location - City or Town, State: Flinstone, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CEREBROVASCULAR ACCIDENT — 5 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION

23b. Did tobacco use contribute to the cause of death? [ ] 1 Yes [X] 2 No [ ] 3 Probably [ ] 4 Unknown

24a. Was an autopsy performed? [ ] 1 Yes [X] 2 No

24b. Were autopsy findings available prior to completion of cause of death? [ ] 1 Yes [X] 2 No

25. Was case referred to medical examiner? [ ] 1 Yes [X] 2 No

26. Place of Death *(Check only one)*: Hospital: [X] 1 Inpatient [ ] 2 ER/Outpatient [ ] 3 DOA — Other: [ ] 4 Nursing Home [ ] 5 Residence [ ] 6 Other *(Specify)*

27. Manner of Death: [X] 1 Natural [ ] 2 Accident [ ] 3 Suicide [ ] 4 Homicide [ ] 5 Pending investigation [ ] 6 Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? [ ] 1 Yes [ ] 2 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: [X] 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [ ] 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] PHYSICIAN

29c. License number: D50844

29d. Date signed *(Month, Day, Year)*: MAY 14 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JOSE T. LOVERA JR., M.D. 912 SETON DRIVE CUMBERLAND, MD

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 14 1998

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

YES

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16113

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCES KESLER HENDERSON
2. Date of Death (Month, Day, Year): May 5, 1998
3. Time of Death: 7:45 am
4a. Facility Name (If not institution, give street and number): Memorial Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 234-38-8170
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 29, 1927
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. Stete: WV
10b. County: Hampshire
10c. City, Town or Location: Green Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: P.O. Box 35
10f. Zip Code: 26722
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorcad
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretery-Clerk
16b. Kind of Business/Industry: RailRoad Tie Treatment Plant

17. Father's Name (First, Middle, Last): William F. Kesler
18. Mother's Name (First, Middle, Meiden Surneme): Edna Virginia Foley

19a. Informant's Name/Relationship (Type, Print): Lilburn W. Henderson Husband
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): P. O. Box 35, Green Spring, WV 26722

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Forest Glen Cemetery
Date: May 7, 1998
20c. Location - City or Town, State: Green Spring, WV

21. Signature of Funeral Service Licensee: Sarah S. Morgret
22. Name and Address of Facility: Shaffer Funeral Home, Inc. 230 East Main St., Romney, WV 26757

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Myocardial Infarction	60 minutes
Due to (or as a consequence of):		
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	Post-Operative Colon Resection	24 hours
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Richard W. Snider MD
29c. License number: D 17246
29d. Date signed (Month, Day, Year): May 5 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Richard Snider, Memorial Hospital, Suite 402, Cumberland, MD 21502

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Frances K. Henderson 234-38-8170

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6
MD

State Registrar

31. Dete filed (Month, Dey, Year): MAY 13 1998
32. Registrer's Signeture:

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16114

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bertha Mae Klay

2. Date of Death (Month, Day, Year): May 8, 1998

3. Time of Death: 1:00 AM

4a. Facility Name (If not institution, give street and number): Vindobona Nursing Home

4b. City, Town, or Location of Death: Braddock Heights

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 217-03-2445

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 98 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 14, 1900

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Thurmont

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1 Clarke Avenue

10f. Zip Code: 21788

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Hammaker Memorials

17. Father's Name (First, Middle, Last): Charles Eyler

18. Mother's Name (First, Middle, Maiden Surname): Nora M. Smith

19a. Informant's Name/Relationship (Type, Print): Allyn Myers, nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 515 Damascus, Maryland 20872

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Green Hill Cemetery

Date: 5/13/98

20c. Location - City or Town, State: Waynesboro, PA

21. Signature of Funeral Service Licensee: Larry R. Savage

22. Name and Address of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Suspected pelvic cancer — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dementia, renal insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kathleen W Stern MD

29c. License number: D32073

29d. Date signed (Month, Day, Year): 5/11/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kathleen W Stern MD 610 Ninth Ave, Brunswick Md 21716

State Registrar

31. Date filed (Month, Day, Year): MAY 12 1998

32. Registrar's Signature: Julie Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Amended Line 8, fchd,JD

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16115

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JENNIE C. WEEDON LEE
2. Date of Death (Month, Day, Year): APRIL 30, 98
3. Time of Death: 1:10 AM
4a. Facility Name (If not Institution, give street and number): 7648 FINGERBOARD RD.
4b. City, Town, or Location of Death: FREDERICK
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 217-32-5225
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 96 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 12, ~~98~~ 1902
9. Birthplace (State or Foreign Country): MD.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD.
10b. County: FREDERICK
10c. City, Town or Location: FREDERICK
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7648 FINGERBOARD RD.
10f. Zip Code: 21704
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5 TH | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOME MAKER
16b. Kind of Business/Industry: DOMESTIC

17. Father's Name (First, Middle, Last): JOHN T. WEEDON
18. Mother's Name (First, Middle, Maiden Surname): JENNIE ROBINSON

19a. Informant's Name/Relationship (Type, Print): BESSIE BROWN DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7648 FINGERBOARD RD. FRED. MD. 21701

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HOPE HILL CEM. Date: 5 MAY 98
20c. Location - City or Town, State: FRED. MD.

21. Signature of Funeral Service Licensee: Gary L. Rollins
22. Name and Address of Facility: GARY L. ROLLINS FUNERAL HOME 110 WEST SOUTH ST. FRED. MD. 21701

Physician /Medical Examiner

KB

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CHF — 24 hrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Aortic Stenosis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: P. Shapiro M.D.
29c. License number: D07186
29d. Date signed (Month, Day, Year): 5/1/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Philip Shapiro, M.D. 814 Toll House Ave. Frederick, Md. 21701

State Registrar

31. Date filed (Month, Day, Year): MAY 05 1998
32. Registrar's Signature: Julia Davidson Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16116

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Edward William Lent, Jr.

2. Dete of Deeth — Month: May 10, Dey, Year: 1998

3. Time of Deeth: 10:22 AM

4e. Facility Neme (If not institution, give street and number): 5417 Manchester Drive

4b. City, Town, or Location of Deeth: Suitland

4c. County of Deeth: Prince George's

Funeral Director

5. Sociel Security Number: 006-14-4417

6. Sex: 1☐M 2☐F — XX

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): Dec 25, 1922

9. Birthplece (Stete or Foreign Country): Patten, ME

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Prince George's

10c. City, Town or Location: Suitland

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street end Number: 5417 Manchester Drive

10f. Zip Code: 20746

10g. Citizen of Whet Counfry?: United States

11. Meritel Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☐No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No Specify: X

14. Rece - American Indien, Bieck, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grede completed): Elementery/Secondery (0-12): 12; College (1-4or 5+): 5+

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Civil Engineer

16b. Kind of Business/Industry: Air Force & PG County

17. Fether's Neme (First, Middle, Last): Edward William Lent, Sr.

18. Mother's Name (First, Middle, Meiden Surneme): Mary Olive Violette

19e. Informent's Neme/Reletionship (Type, Print): Norine E. Lent (WIFE)

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 5417 Manchester Drive, Suitland, Maryland 20746

20e. Method of Disposition: ☒Buriel 2☐Cremetion 3☐Removel from Stete 4☐Donetion 5☐Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): June 1, 1998 Arlington National Cemetery

20c. Location - City or Town, Stete: Arlington Virginia

21. Signature of Funeral Service Licensee: [signature]

22. Neme end Address of Fecility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

Physician /Medical Examiner

23a. Pert 1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. terminal multiple sclerosis

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediefe cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest:

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐Yes 2☒No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

26. Piece of Deeth (Check only one): Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Menner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐**Medical Examiner:** On the besis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner stated.

29b. Signeture end fitle of certifier: Suzanne M Allen

29c. License number: WA MD 0003855

29d. Dete signed (Month, Day, Yeer): 12 May 98

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Suzanne M. Allen MD 1075 W. Perimeter Rd Andrews AFB MD 20762

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 13 1998

32. Registrer's Signeture: Julie Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16117

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gladys Lillian Lancaster
2. Data of Death Month / Day / Yaar: May 13, 1998
3. Time of Death: 8:10 P.M.
4a. Facility Name *(If not institution, giva straat and number)*: Devlin Manor Nursing Home
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 237-48-2192
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 86 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Dey, Year)*: May 29, 1911
9. Birthplaca *(Stata or Foraign Country)*: Maryland

Usual Raaidance of Dacedant

10a. Stata: West Virginia
10b. County: Mineral
10c. City, Town or Location: Ridgeley
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: Route-3 Box-9
10f. Zip Code: 26753
10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Marriad 2☐ Marriad 3☒ Widowad 4☐ Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indian, Black, White, atc. *Specify:* white

15. Decadant's Education *(Spacify only highast grada complatad)*: Elamentary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Homemaker
16b. Kind of Businass/Industry: Home

17. Fathar's Nama *(First, Middle, Last)*: Samuel Sipes
18. Mothar's Nama *(First, Middle, Maiden Surnama)*: Mazzie Blanche Stottlemyer

19a. Informant's Name/Ralationship *(Type, Print)*: Mrs. Janice Seely / Daughter
19b. Mailing Address *(Straat and Numbar or Rural Routa Numbar, City or Town, State, Zip Code)*: 44203 670 E. Tuscarawas Ave. Barberton, Ohio

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Spacify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar placa)*: Sunset Memorial Park
Data: May 18, 1998
20c. Location - City or Town, Stata: Cumberland, Md.

21. Signatura of Funaral Sarvica Licensaa: Ernest A. Riley, Jr.
22. Nama and Addrass of Facility: Leasure-Stein Funeral Home, 230 Baltimore Ave. Cumberland, Md. 21502

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immadiata Causa (Final disaasa or condition rasulting in daath)
a. Irreversible Congestive Cardiac failure — 2 month
Dua to (or as a consaquanca of):
Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury thet initiated evants rasulting in daath) Last
b. Severe Cardiomyopathy — 8 month
Dua to (or as a consaquanca of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Othar significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.: Cachexia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Ware autopsy findings availabla prior to compiation of causa of daath? 1☐ Yes 2☐ No

25. Was case rafarrad to medical examinar? 1☐ Yes 2☒ No
26. Placa of Daath *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☒ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarmined
28a. Date of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha time, data and placa, and due to tha causa(s) and mannar as statad. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha time, data and placa, and dua to tha cause(s) and mannar stated.
29b. Signatura and titla of certifiar: N.A. Rajsthan MD
29c. Licansa numbar: D19318
29d. Data signad *(Month, Day, Year)*: May 14th 1998
30. Nama and addrass of parson who completed causa of daath (Item 23a) (Type, Print): N.A. Rajsthan MD 517 old Town Rd Cumberland Md 21502

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 15 1998
32. Registrar's Signatura:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Health and Mantal Hygiana. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, paga 2 should be detached for use as the burial-transit

8

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16118

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ethel Pearl Lease

2. Date of Death Month Day Year: MAY 9 1998

3. Time of Death: 9:40

4a. Facility Name *(If not institution, give street and number)*: Sacred Heart Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 216-07-2726

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: July 4, 1907

9. Birthplace *(State or Foreign Country)*: WV

Usual Residance of Decedant

10a. Stata: Md

10b. County: Allegany

10c. City, Town or Location: Westernport

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 21418 Creek Side Drive, SW

10f. Zip Code: 21562

10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Dacedant Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexicen, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grade compiated)*: Elementary/Secondary (0-12): Unknown; Collaga (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Homemaker

16b. Kind of Businass/Industry: Home

17. Fathar's Nama *(First, Middla, Last)*: John William Paton

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Viola Pearl Smiley

19a. Informant's Name/Relationship *(Type, Print)*: Judy A. Ewell

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 111 Highland Drive, Warner Robins, GA 31088

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Ptace of Disposition *(Nama of cemetary, cramatory or othar place)*: Mountain View Cemetery

Data: 5/11/98

20c. Location - City or Town, Stata: Moscow Mills, Md

21. Signatura of Funaral Sarvice Licensaa: F. Wayne Boal

22. Nama and Addrass of Facility: Boal Funeral Home, 111 Church Street, Westernport, MD 21562

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina.

Approximate Intarval Between Onset and Death

Immediata Causa (Final disaasa or condition rasulting in daath)

a. Congestive heart Failure — 1 year

Dua to (or as a consequanca of):

b. Atherosclerotic heart Disease — 40 years

Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disaase or injury that initiated events rasulting in daath) Last

Dua to (or as a consequance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa givan in Part I.

Hypertension. Aortic Stenosis, Renal Failure

Chronic atrial fibrillation. Recent Stroke

Diabetes mellitus. old age.

23b. Did tobacco use contributa to the cause of death? 1☐ Yas 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to compiation of cause of daath? 1☐ Yes 2☐ No

25. Was case referrad to medical examinar? 1☐ Yas 2☑ No

26. Placa of Death *(Check only ona)*: Hospital: 1☑ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Time of injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. *(Spacify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledga, daath occurrad at tha tima, data and ptace, and dua to the causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurrad at the tima, data and ptace, and due to tha cause(s) and mannar stated.

29b. Signatura and titla of certifiar: S. L. Sandhir M.D.

29c. Licensa number: D14464

29d. Data signad *(Month, Day, Year)*: MAY 11 1998

30. Nama and address of person who completad cause of death (Item 23a) (Type, Print): Sikander Sandhir M.D. 48 Tarn Terrace Frostburg MD 21532.

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 13 1998

32. Registrar's Signatura

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16119

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marguerite H. Mehringer
2. Date of Death: Month May Day 9 Year 1998
3. Time of Death: 4:55am
4a. Facility Name (If not institution, give street and number): Wilson Health Care Center
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 021-20-8011
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 4, 1914
9. Birthplace (State or Foreign Country): Nova Scotia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 415 Russell Avenue
10f. Zip Code: 20877
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): George Hirtle
18. Mother's Name (First, Middle, Maiden Surname): Annie L. Meisner

19a. Informant's Name/Relationship (Type, Print): Frank H. Mehringer/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 415 Russell Avenue, Gaithersburg, Maryland 20877

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematorium
Date: 5/9/1998
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Isobel D Wynn
22. Name and Address of Facility: Olin L. Molesworth P. A. Funeral Home, 26401 Ridge Road, Damascus, Maryland 20872

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	recurrent cerebrovascular accident	1 week
Due to (or as a consequence of): b.	hypertension	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John R Melnick MD
29c. License number: D19294
29d. Date signed (Month, Day, Year): May 9, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John R. Melnick 911 Russell Ave Gaithersburg Md. 20879

State Registrar

31. Date filed (Month, Day, Year): MAY 11 1998
32. Registrar's Signature: Debi Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16120

Physician /Medical Examiner

1. Decedent's Nama *(First, Middle, Last)*: ALMA GEORGEANNA McGROARTY
2. Data of Death Month / Day / Yaar: May 7 1998
3. Time of Death: 12:45pm
4a. Facility Nema *(If not institution, giva street and number)*: Shady Grove Nursing Center
4b. City, Town, or Location of Deeth: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Sacurity Number: 223-38-2158
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 97 Yrs. | If Undar 1 Yeer: Months / Deys | If Undar 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Sept.9 1900
9. Birthplace *(Stata or Foraign Country)*: North Carolina

Usual Residence of Decedant

10a. Stata: Md.
10b. County: Montgomery
10c. City, Town or Location: Barnesville
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street and Numbar: 18120 Barnesville Road
10f. Zip Coda: 20838
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☒ Navar Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Dacedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- if Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*
14. Rece - Amaricen Indian, Black, Whita, atc. *Specify:* White

15. Dacedant's Education *(Specify only highast grada complatad)*: Elementary/Secondary (0-12): 12 | Collega (1-4or 5+):
16a. Decedant's Usuel Occupation *(Give kind of work dona during most of working lifa. DO NOT usa ratired)*: librarian
16b. Kind of Businass/Industry: Alexandria Library

17. Father's Neme *(First, Middla, Last)*: William B. McGroarty
18. Mothar's Name *(First, Middle, Maiden Surname)*:

19a. Informent's Name/Ralationship *(Typa, Print)*: Mary White Lok/Friend
19b. Melling Addrass *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: P.O. Box 333 Barnesville, Md. 20838

20a. Method of Disposition: 1☑ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cematery, cramatory or other place)*: Oak Wood Cemetery — Data: 5/11
20c. Location - City or Town, Stata: Falls Church, Va.

21. Signatura of Funaral Sarvice Licensee: Wilbur O. Dick
22. Nama and Addrass of Facility: Hilton Funeral Home P.O. Box 86 Barnesville, Md. 20838

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter tha disaase, or complicetions that caused tha daath. Do not antar tha moda of dying, such es cardiac or raspiratory arrast, shock, or haert failure. List only ona causa on aach line.

Approximeta Intarval Batween Onsat and Deeth

Immadiata Causa (Finai disaasa or condition rasulting in death)
a. chronic obstructive pulmonary disease — 6 months

Dua to (or as a consequance of):

Sequantially list conditions, if any, laading to immediate causa. Entar Underlying Cause (Disaase or Injury thet initiated events rasulting in death) Last
b.
Dua to (or es e consaquance of):
c.
Dua to (or es e consaquance of):
d.

Part fi. **Other significant conditfons** contributing to death but not rasulting in the underlying ceusa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Wara autopsy findings availebla prior to compiation of causa of daath? 1☐ Yas 2☑ No

25. Was casa refarrad to medicei exeminar? 1☐ Yes 2☑ No

26. Place of Deeth *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☑ Nursing Homa 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Piece of injury - At homa, farm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Steta)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the bast of my knowledge, deeth occurred at tha time, dete end place, and dua to the cause(s) end menner as stated. 2☐ **Medicaf Examiner:** On tha basis of exemination end/or invastigation, in my opinion, deeth occurred at tha tima, dete and piece, and due to tha ceuse(s) and mannar stated.

29b. Signature and titla of certifiar: Leonard Sax MD
29c. License numbar: D38076
29d. Dete signed *(Month, Day, Year)*: May 8 1998

30. Neme and eddrass of person who completed cause of deeth (Item 23a) (Type, Print): Leonard Sax MD 19710 Fisher Poolesville MD 20837

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificata be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 12 1998
32. Registrar's Signatura: Julia Davidson Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16121

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THOMAS FRANCIS McNICKLE

2. Date of Death (Month, Day, Year): April 28, 1998

3. Time of Death: 6:00 AM

4a. Facility Name (If not institution, give street and number): 6829 Plantation Road

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 579-10-2580

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 24, 1922

9. Birthplace (State or Foreign Country): D.C.

Usual Residance of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6829 Plantation Road

10f. Zip Code: 21701

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1 [ ] Naver Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Orlgin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - Amarican indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lab Technician

16b. Kind of Business/Industry: VA Medical Center

17. Father's Name (First, Middle, Last): Thomas Joseph McNickle

18. Mother's Name (First, Middle, Maiden Surname): Christine Mary Rankin

19a. Informant's Name/Relationship (Type, Print): Margaret McNickle (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6829 Plantation Road, Frederick, Maryland 21701

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Placa of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park

Date: 5/2/98

20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey

22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701

Physician /Medical Examiner

KB

23a. Part I. Enter the disease, or complications that caused the death. Do not entar the moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on eachline.

Approximata Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death) a. ASCVD. — 10-12yrs

Due to (or as a consequence of):

Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b.

Due to (or as a consequance of):

c.

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one) — Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Yaar)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. Licansa number: D-31912

29d. Data signad (Month, Day, Year): 04/30/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Julio Menocal, MD 1564 Opossumtown Pike, Frederick, Maryland 21701

State Registrar

31. Date filed (Month, Day, Year): APR 30 1998

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16122

WILLIAM A. MANN

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Arthur Mann
2. Date of Death: Month May Day 7 Year 1998
3. Time of Death: 2:30 am
4a. Facility Name (If not institution, give street and number): The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 215-32-5118
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): April 10, 1937
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Caroline
10c. City, Town or Location: Federalsburg
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 306 Greenridge Road
10f. Zip Code: 21632
10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: Black & Decker

17. Father's Name (First, Middle, Last): Samuel Mann
18. Mother's Name (First, Middle, Maiden Surname): Evelyn Bowman

19a. Informant's Name/Relationship (Type, Print): Barbara Ann Mann, wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 306 Greenridge Road, Federalsburg, MD 21632

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Evergreen Memorial Gardens Date: 05/11/98
20c. Location - City or Town, State: Finksburg, MD

21. Signature of Funeral Service Licensee: Katherine Pritts - Switzer
22. Name and Address of Facility: Pritts Funeral Home & Chapel, 412 Washington Rd., Westminster, MD 21157

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypotension / Respiratory Arrest — ≈ 1 hr
Due to (or as a consequence of):
b. Metastatic CA — Months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☒ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D52856
29d. Date signed (Month, Day, Year): 5/7/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Cynthia Rubio, MD THE MEMORIAL HOSPITAL, 219 S. Washington Rd/ST, EASTON MD 21601

State Registrar

31. Date filed (Month, Day, Year): MAY 11 1998
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16123

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY ELLEN MURRAY
2. Date of Death Month Day Year: MAY 8, 1998
3. Time of Death: 10:10 AM
4a. Facility Name *(If not institution, give street and number)*: 5235 BYERLY ROAD
4b. City, Town, or Location of Death: UPPERCO
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 217-18-8964
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 29,1906
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10e. State: MARYLAND
10b. County: CARROLL
10c. City, Town or Location: FINKSBURG
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2912 CEDARHURST ROAD
10f. Zip Code: 21048
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: GEORGE W. KNOUSE
18. Mother's Name *(First, Middle, Maiden Surname)*: NANCY E. MILLER

19e. Informent'a Name/Reletionship *(Type, Print)*: BETTY E. NUSBAUM, DAUGHTER
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 5235 BYERLY RD, UPPERCO, MD 21155

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: EVERGREEN MEMORIAL GARD
Date: 5/12
20c. Location - City or Town, State: FINKSBURG, MD

21. Signeture of Funeral Service Licensee: ▶ Steven W Eline
22. Name and Address of Facility: ELINE FUNERAL HOME 934 SOUTH MAIN ST, HAMPSTEAD, MD 21074

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Ceuse (Final disease or condition resulting in death) a.	CVA	6 wks
Due to (or es a consequence of):		
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest b.	ASCVD	10 yrs
Due to (or as a consequence of):		
c.		
Due to (or es e consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cauas of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings avellable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ John W Middleton
29c. License number: D25443
29d. Date signed *(Month, Dey, Yeer)*: 5-8-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN W. MIDDLETON MD 688 Poole Road Westminster Md 21157

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 11 1998
32. Registrar's Signature: Julia Thurlow Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The lew requiras thet tha daath certificata be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16124

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joseph Ellsworth Matthews

2. Data of Death Month / Day / Year: MAY 11 1998

3. Time of Death: 7:55 AM

4e. Facility Name *(If not institution, give street and number)*: Sacred Heart Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 217-30-1898

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 28, 1933

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedant

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Eckhart Mines

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 17012 Neff Street S.W.

10f. Zip Code: 21528

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Labor

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: James Matthews

18. Mother's Name *(First, Middle, Maiden Surname)*: Venona Kirkwood

19a. Informant's Name/Relationship *(Type, Print)*: Patricia J. Matthews wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 17012 Neff Street S.W., Eckhart Mines, MD 21528

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Smithburg Crematory

Date: May 13, 1998

20c. Location - City or Town, State: Smithburg, MD

21. Signature of Funeral Service Licensee: James E McKenzie

22. Name and Address of Facility: Eichhorn-McKenzie Funeral Home P.A. 8 E. Main Street, Lonaconing, MD 21539

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Adenocarcinoma, Bronchus — 8 mos

Due to (or as a consequence of):
b. Metastatic Disease, Liver — 8 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. COPD — 10 yrs

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Angel Rosario MD

29c. License number: D13166

29d. Date signed *(Month, Day, Year)*: MAY 11 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANGEL H. ROSARIO MD. 48 PARK TERRACE FROSTBURG, MD 21532

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 13 1998

32. Registrar's Signature

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

3

YRS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16125

Item: 5 per F.H. G-760 6/12/98 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DELBERT ELWOOD MILLS
2. Date of Death Month: MAY Day: 7 Year: 1998
3. Time of Death: 10:30 A
4a. Facility Name (If not Institution, give street and number): BROOKE GROVE REHABILITATION NURSING CENTER
4b. City, Town, or Location of Death: SANDY SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 233-44-~~5106~~ 5108
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 9 1914
9. Birthplace (State or Foreign Country): West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: WV
10b. County: Mineral
10c. City, Town or Location: Keyser
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: Rt 4, Box 66
10f. Zip Code: 26726
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: 1944 1970
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sergeant First Class
16b. Kind of Business/Industry: U.S. Army
17. Father's Name (First, Middle, Lest): James Meese Mills
18. Mother's Name (First, Middle, Melden Surneme): Grace Rotruck
19a. Informant's Neme/Reletionship (Type, Print): Carol J. Mills Daughter
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 205 Yoakum Parkway Apt 522 Alexandria, VA 22304
20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Potomac Memorial Gardens Date: May 9, 1998
20c. Location - City or Town, State: Keyser, WV 26726
21. Signeture of Funeral Service Licensee: A. Gray Rotruck
22. Name and Address of Facility: Rotruck-Smith Funeral Home 85 South Main Street Keyser, WV 26726

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate interval Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in deeth)
a. ACUTE RENAL FAILURE — DAYS

Due to (or as a consequence of):
b. SEPSIS — DAYS

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Last
Due to (or es e consequence of):
c. PNEUMONIA (PROBABLE) — DAYS

Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: SENILE DEMENTIA; CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Piece of Deeth (Check only one): Hospital: 1 [ ] inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of injury (Month, Day Year)
28b. Time of injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and menner es steted. 2 [ ] Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier: STAFF PHYSICIAN
29c. License number: D42046
29d. Dete signed (Month, Dey, Year): May 7, 1998

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): GRACE BROOKE HUFFMAN, MD 18100 SLADE SCHOOL ROAD SANDY SPRING, MARYLAND 20860

State Registrar

31. Date filed (Month, Dey, Year): MAY 12 1998
32. Registrar's Signeture:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16126

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY ANGELA MEYER

2. Date of Death Month / Day / Year: MAY 9 1998

3. Time of Death: 8:15 A.M.

4a. Facility Name *(If not institution, give street end number)*: 39 BLAIR STREET

4b. City, Town, or Location of Death: FROSTBURG

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 212 01 9733

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: AUG 24 1916

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: FROSTBURG

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 39 BLAIR STREET

10f. Zip Code: 21532

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: JOSEPH SACCO

18. Mother's Name *(First, Middle, Maiden Surname)*: CARMELLA BUFFER

19a. Informant's Name/Relationship *(Type, Print)*: RICHARD MEYER / SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5 METZ COURT, GERMANTOWN, MD 20874

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: REST LAWN MEMORIAL GARDENS — Date: 5/11/98

20c. Location - City or Town, State: LaVALE, MD 21502

21. Signature of Funeral Service Licensee: Marilou M. Sowers

22. Name and Address of Facility: SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. MESOTHELIOMA, PLEURA, (L) — 4 MOS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Angel Rogue MD

29c. License number: D13166

29d. Date signed *(Month, Day, Year)*: 5/11/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANGEL M. ROGUE MD 48 Dann Terrace Frostburg Md 21532

State Registrar

31. Date Filed *(Month, Day, Year)*: MAY 12 1998

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16127

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Estella	Collins	Norris	May 8, 1998	2:30 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2103 Curtis Court	Sykesville	Carroll

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218 40 8686	1☐ M 2☒ F	54 Yrs.			Feb. 25, 1944	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Carroll	Sykesville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2103 Curtis Court	21784	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12		clerical	mortgage company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Norman Collins Sr.	Maryanna Brown

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Hayes Norris (spouse)	2103 Curtis Court Sykesville, Md.21784

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	St. Luke's Cemetery	5-11-98	Sykesville, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Harry W. Haight	Haight Funeral Home P.O.Box 195 Sykesville,Md. 21784

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. COLON CANCER	18 MOS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, snd due to the ceuse(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D35606	5/8/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SAMUEL ZT BAKER MD 21 CROSSROADS DR #415 OWINGS MILLS MD 21117

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 11 1998	Julie Davidson-Bardell

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16128

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Henry Oliver

2. Date of Death (Month, Day, Year): May 3, 1998

3. Time of Death: 10:25PM

4a. Facility Name (If not institution, give street end number): 10907 Old Fort Road

4b. City, Town, or Location of Death: Ft. Washington

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-46-1903

6. Sex: 1 [X] M 2 [ ] F

7. Age (in yrs. last birthday): 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 19, 1935

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Fort Washington

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 10907 Old Fort Road

10f. Zip Code: 20744

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 12th

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Analyst

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Benjamin F. Oliver, Sr.

18. Mother's Name (First, Middle, Meiden Surname): Hazel C. Cash

19a. Informent's Name/Reletionship (Type, Print): Helen V. Schaeffer (Sister)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2001 Tinker Dr. Ft. Washington MD 20744

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Maryland State Veterans Cem

Date: May 8, 1998

20c. Location - City or Town, Stete: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: ▶ Stu E. Sitt

22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haelth and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final diseese or condition resulting in death)

a. Metastatic Cancer - unknown primary

Due to (or as e consequence of):

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last

b. Submandibular Cancer

Due to (or es e consequence of):

c. Hypertension

Due to (or as a consequenca of):

d.

Part II. **Other eignificant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. **Did tobacco use contribute to the cause of deeth?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No N/A

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and menner stated.

29b. Signeture and title of certifier: ▶ Karenga R. Lemmons MD

29c. License number: D31711 (MD)

29d. Dete signed (Month, Day, Year): 5/5/98

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Karenga R. Lemmons M.D.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAY 13 1998

32. Registrar's Signature: Julia Strudwick Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16129

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David William Penn

2. Date of Death — Month: MAY; Day: 11; Year: 1998

3. Time of Death: 7:15PM

4a. Facility Name (If not institution, give street and number): CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death: La PLATA

4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 578-01-4764

6. Sex: X 1 M 2 F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): APRIL 04-13-1919

9. Birthplace (State or Foreign Country): WashingtonDC

Usual Residence of Decedent

10a. State: MD

10b. County: Charles

10c. City, Town or Location: Nanjemoy

10d. Inside City Limits: 1 Yes 2 X No

10e. Street and Number: 8005 Gilroy Road

10f. Zip Code: 20662

10g. Citizen of What Country: USA

11. Marital Status: 1 Never Married 2 X Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No — If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 10 — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist

16b. Kind of Business/Industry: Washington Navy Yd.

17. Father's Name (First, Middle, Last): David William Penn

18. Mother's Name (First, Middle, Maiden Surname): Lucy Eleanore Chism Penn

19a. Informant's Name/Relationship (Type, Print): Dorothy Penn/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8005 Gilroy Rd. Nanjemoy, MD.20662

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Md. Veterans Cemetery

Date: 5/15/98

20c. Location - City or Town, State: Cheltenham,MD.

21. Signature of Funeral Service Licensee: Stanton C. Echols III 10081

22. Name and Address of Facility: Arehart-Echols Funeral HOME PA
P.O. 567 La PLata, Md.20646

To Be Completed by Funeral Director

David Penn

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Congestive Heart Failure

Due to (or as a consequence of):
b. Chronic Obstructive Lung Dis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

28. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael O Leather

29c. License number: D-21031

29d. Date signed (Month, Day, Year): 5/12/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MICHAEL LEATHERWOOD,MD 7OOOLD LINE CENTER,SUITE 202,WALDORF, MARYLAND 20601

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAY 13 1998

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16130

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELTON W. PARSONS

2. Date of Death — Month: 5 Day: 12 Year: 98

3. Time of Death: 2030

4a. Facility Name *(If not institution, give street and number)*: Atlantic General Hospital

4b. City, Town, or Location of Death: Berlin

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 068-09-8064

6. Sex: ☒ 1 M ☐ 2 F

7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 4/30/12

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Berlin

10d. Inside City Limits: ☒ 1 Yes ☐ 2 No

10a. Street and Number: 5 Washington St.

10f. Zip Code: 21811

10g. Citizen of What Country?: USA

11. Marital Status: ☐ 1 Never Married ☒ 2 Married ☐ 3 Widowed ☐ 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? ☐ 1 Yes ☒ 2 No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) ☐ 1 Yes ☒ 2 No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): — College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Salesman

16b. Kind of Business/Industry: Car Dealership

17. Father's Name *(First, Middle, Last)*: Charles Parsons

18. Mother's Name *(First, Middle, Maiden Surname)*: Mae White

19a. Informant's Name/Relationship *(Type, Print)*: Florence Parsons/ Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5 Washington St. Berlin, MD 21811

20a. Method of Disposition: ☒ 1 Burial ☐ 2 Cremation ☐ 3 Removal from State ☐ 4 Donation ☐ 5 Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Evergreen Cemetery

Date: 5/16/98

20c. Location - City or Town, State: Berlin, MD

21. Signature of Funeral Service Licensee: W. Zeke Burbage

22. Name and Address of Facility: Burbage Funeral Home 108 William St. Berlin, MD 21811

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. COPD.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Chronic atrial fibrillation

23b. Did tobacco use contribute to the cause of death? ☐ 1 Yes ☒ 2 No ☐ 3 Probably ☐ 4 Unknown

24a. Was an autopsy performed? ☐ 1 Yes ☒ 2 No

24b. Were autopsy findings available prior to completion of cause of death? ☐ 1 Yes ☐ 2 No

25. Was case referred to medical examiner? ☐ 1 Yes ☒ 2 No

28. Place of Death *(Check only one)* — Hospital: ☐ 1 Inpatient ☒ ER/Outpatient ☐ 3 DOA — Other: ☐ 4 Nursing Home ☐ 5 Residence ☐ 8 Other *(Specify)*

27. Manner of Death: ☒ 1 Natural ☐ 2 Accident ☐ 3 Suicide ☐ 4 Homicide ☐ 5 Pending investigation ☐ 6 Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? ☐ 1 Yes ☐ 2 No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: ☒ 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: C. Huddleston

29c. License number: D29105

29d. Date signed *(Month, Day, Year)*: 5/14/98.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christjon Huddleston, MD 106 Milford St. Suite 103 Salisbury, MD 21801

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 15 1998

32. Registrar's Signature: Julia Davidson-Kendall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16131

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES PRATT
2. Date of Death: Month MAY Day 12 Year 1998
3. Time of Death: 2:10 AM
4a. Facility Name (If not institution, give street and number): FROSTBURG VILLAGE NURSING HOME
4b. City, Town, or Location of Death: FROSTBURG
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 163-24-4673
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUGUST 25 1925
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: CUMBERLAND
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 223 BALTIMORE AVENUE
10f. Zip Code: 21502
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): JANITOR
16b. Kind of Business/Industry: JANITOR

17. Father's Name (First, Middle, Last): JOHN ANDREW PRATT
18. Mother's Name (First, Middle, Maiden Surname): DORCAS ELIZABETH CRIGER

19a. Informant's Name/Relationship (Type, Print): VICKIE BAKER NIECE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 884 FINZEL ROAD FROSTBURG, MARYLAND 21532

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place) / Date: ST PATRICKS CATHOLIC CEMETERY MAY
20c. Location - City or Town, State: 14 1998 MT SAVAGE MD.

21. Signature of Funeral Service Licensee: Dale L. Merritt
22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
e. Acute Myocardial Infarction — 4 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

History of recent Stroke
History of Recent Cardiac Dysrhythmia.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D 21244
29d. Date signed (Month, Day, Year): MAY 12, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR JESUS H. TAN FROSTBURG PLAZA FROSTBURG, MARYLAND 21532

State Registrar

31. Date filed (Month, Day, Year): MAY 13 1998
32. Registrar's Signature:

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Yes

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16132

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Gene Rice , Sr.

2. Date of Death (Month, Day, Year): May 9, 1998

3. Time of Death: 6:28 P.M.

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 212-38-8643

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 56 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 27, 1941

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 27 East Third St.

10f. Zip Code: 21701

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Postal Clerk

16b. Kind of Business/Industry: U.S. Post Office

17. Father's Name (First, Middle, Last): Howard D. Rice, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Ida V. Shaw

19a. Informant's Name/Relationship (Type, Print): Richard G. Rice, Jr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 108 Debra Dr./ Stafford, Virginia 22554

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Park Heights Cemetery

Date: 5-13-98

20c. Location - City or Town, State: Brunswick, Maryland

21. Signature of Funeral Service Licensee: Raymond Peterson

22. Name and Address of Facility: Stauffer Funeral Home, 1621 Opossumtown Pike/ Frederick, Maryland 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Coronary artery Disease — Approximate Interval Between Onset and Death: Years

Due to (or as a consequence of):
b. Generalized atherosclerosis — Years.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. — Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic alcoholism

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ronald Miller M.D.

29c. License number: D26499

29d. Date signed (Month, Day, Year): 5-9-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ronald E. Miller, M.D. / 4 Culwell Dr. / Mt. Airy, Maryland 21771

State Registrar

31. Date filed (Month, Day, Year): MAY 12 1998

32. Registrar's Signature: Lisa Davidson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16133

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: FLORENCE KATHRYN ROBINSON
2. Dete of Death Month / Dey / Year: May 3, 1998
3. Time of Deeth: 12:44 PM
4e. Facility Neme *(If not institution, give street end number)*: Frederick Memorial Hospital
4b. City, Town, or Location of Deeth: Frederick
4c. County of Death: Frederick

Funeral Director

5. Sociel Security Number: 215-38-2584
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. lest birthdey)*: 89 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Nov. 30, 1908
9. Birthplece *(State or Foreign Country)*: Pennsylvania

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 6846 Buttonwood Ct.
10f. Zip Code: 21703
10g. Citizan of Whet Country?: USA
11. Maritel Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detas:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indian, Bleck, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grede completad)*: Elamantary/Secondary (0-12); College (1-4or 5+): 4
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working lifa. DO NOT usa ratired)*: School Teacher
16b. Kind of Business/Industry: Public Education
17. Fether's Nema *(First, Middle, Last)*: Harry Blaine Snyder
18. Mother's Name *(First, Middle, Meiden Surneme)*: Kathryn (Unknown) Zartman
19a. Informent's Name/Reletionship *(Type, Print)*: Sue Wilson, daughter
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 633 Hilltop Dr., Cumberland, MD 21502
20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Dispositon *(Neme of cemetary, crematory or othar piece)*: Hagerstown Crematory
Dete: 5/5/98
20c. Location - City or Town, State: Hagerstown, Maryland
21. Signature of Funeral Service Licensee: Ryan M. Berger
22. Neme end Address of Feciity: Stauffer Funeral Home, 1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

Approximete Intervel Between Onset end Deeth

Immediete Cause (Finel disease or condition resulting in deeth): a. RUPTURED ABDOMINAL AORTIC ANEURYSM — 2 hours

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediete causa. Entar Underlying Cause (Disaese or injury thet initieted avants resulting in deeth) Lest:

b. Due to (or es e consequence of):

c. Due to (or es e consequenca of):

d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.: EMPHESEMA

23b. Did tobecco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of daath? 1☐ Yes 2☒ No

25. Wes case refarrad to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpetient 3☐ DOA; Othar: 4☐ Nursing Home 5☐ Residanca 6☐ Other *(Specify)*

27. Mannar of Death: 1☒ Neturel 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, death occurred et tha time, data and plece, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, daath occurred et tha time, data end pleca, end dua to the causa(s) end menner steted.

29b. Signature end title of certifier: Jonathan Grife MD

29c. License number: D50990

29d. Dete signed *(Month, Dey, Yeer)*: May 6, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Jonathan Grife M.D., 915 Toll House Avenue, Frederick, MD

State Registrar

31. Dete filed *(Month, Dey, Yaer)*: MAY 07 1998

32. Registrer's Signeture: Judi Davidson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16134

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PAUL K. RUPPERT, SR.

2. Date of Death Month: 05 Day: 07 Year: 98

3. Time of Death: 0100

4a. Facility Name *(If not institution, give street and number)*: ATLANTIC GENERAL HOSPITAL

4b. City, Town, or Location of Death: BERLIN

4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 579-24-9187

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 4/27/25

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Ocean City

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 746 94th St.

10f. Zip Code: 21842

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Co-ordinator

16b. Kind of Business/Industry: Pharmaceutical Co.

17. Father's Name *(First, Middle, Last)*: Carl Ruppert

18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Krogmann

19a. Informant's Name/Relationship *(Type, Print)*: Ethel Ruppert/ Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 746 94th St. Ocean City, MD 21842

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Sunset Memorial Park

Date: 5/11/98

20c. Location - City or Town, State: Berlin, MD

21. Signature of Funeral Service Licensee: W. Fred Burbage

22. Name and Address of Facility: Burbage Funeral Home, 108 William St. Berlin, MD 21811

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. ACUTE MYOCARDIAL INFARCTION — FEW MINUTES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. CAD — FEW YEARS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? ☒ Yes 2 ☐ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dorothy C. Hogworth, M.D.

29c. License number: D06741

29d. Date signed *(Month, Day, Year)*: 05-07-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DOROTHY C. HOGWORTH, M.D. 203 SNOW ST. SNOW HILL, MD. 21863

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 11 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Paul K. Ruppert SR. SS# 579-24-9187 5/7/98 0100

8+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Replacement

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98-16135

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOAN MARIE SELLECK

2. Date of Death Month Day Year: MAY 09 1998

3. Time of Death: 1:30am

4a. Facility Name (If not institution, give street and number): 11802 Elderberry Drive

4b. City, Town, or Location of Death: Germantown

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 202-26-3290

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 4 1935

9. Birthplace (State or Foreign Country): PA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Germantown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11802 Elderberry Drive

10f. Zip Code: 20876

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Teaching

17. Father's Name (First, Middle, Last): Earl Denver Young

18. Mother's Name (First, Middle, Maiden Surname): Grace Steafather

19a. Informant's Name/Relationship (Type, Print): Carl E. Selleck/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11802 Elderberry Dr.Germantown, MD 20876

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Heffner Crematory

Date: 5/10

20c. Location - City or Town, State: York, PA

21. Signature of Funeral Service Licensee: ▶ Wells C Hilton

22. Name and Address of Facility: Hilton Funeral Home Box 86 Barnesville, MD 20838

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung cancer — Approximate Interval: 4 mos.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ John R. Melnick MD

29c. License number: D 19294

29d. Date signed (Month, Day, Year): May 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): John R. Melnick 911 Russell Ave Gaithersburg Md 20879

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): JUN 17 1998

32. Registrar's Signature: ▶ Julie Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16136

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Annabelle Mary Shank

2. Date of Death (Month, Day, Year): April 22, 1998

3. Time of Death: 10:24 PM

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 216-70-0183

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Apr. 11, 1912

9. Birthplaca (State or Foreign Country): Md.

Usual Rasidance of Decedant

10a. Stata: Md.

10b. County: Frederick

10c. City, Town or Location: Middletown

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 7008 Mt. Church Rd.

10f. Zip Coda: 21769

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grada compliated): Elementary/Secondary (0-12): 7 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Businass/Industry: own home

17. Fathar's Nama (First, Middle, Last): Edgar Rohrback

18. Mothar's Nama (First, Middle, Maidan Surnama): Esta Fink

19a. Informant's Name/Ralationship (Type, Print): Janet L. Taulton (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 7102 Mt. Church Rd., Middletown, Md. 21769

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cemetery Locust Valley Bible Church

Data: 4/27

20c. Location - City or Town, Stata: Middletown, Md.

21. Signatura of Funaral Sarvica Licensee: Donald B Thompson

22. Nama and Address of Facility: Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769

Physician /Medical Examiner

23a. Part1. Entar the disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only one causa on aach line.

		Approximate Interval Between Onset and Death
Immediate Causa (Final disaasa or condition resulting in death) a.	Congestive heart failure	12 years
Dua to (or as a consequance of): b.	Diabetic cardiovascular disease	years
Sequantially list conditions, if any, laading to immadiate causa. Entar Undarlying Causa (Diseasa or Injury that initiated avants rasulting in daath) Last — Dua to (or as a consequanca of): c.	Diabetes mellitus	years
d.		

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☑ No

24b. Wara autopsy findings availabla prior to compliation of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to madical examiner? 1☐ Yas 2☑ No

26. Placa of Daath (Check only one) — Hospital: 1☐ Inpatiant 2☑ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending Invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one): 1☑ **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examinar:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at the tima, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signatura and titla of cartifiar: Kathleen W Stern MD

29c. Licansa number: D32073

29d. Data signad (Month, Day, Year): 4/23/98

30. Nama and addrass of parson who compliated causa of daath (Itam 23a) (Type, Print): Kathleen W Stern MD, 610 Ninth Ave, Brunswick, Md. 21716

State Registrar

31. Data filad (Month, Day, Year): MAY 15 1998

32. Registrar's Signatura: Julie Davidson Randall

DHMH 16 Rav 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16137

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Noble	Stull Sr.		May 10, 1998	1 P. M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Citizens Nursing Home	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yaar: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplace (State or Foreign Country)
214-10-4483	1☒ M 2☐ F	84 Yrs.			Mar. 28, 1914	Pa.

Usual Residance of Decedant

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Frederick	Frederick	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
5609 Calvert Dr.	21701	U.S.A.

11. Marital Status	12. Was Decedant Evar in U.S. Armed Forcas?	13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.)	14. Race - Amarican Indian, Black, White, atc.
1☐ Navar Marriad 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:	1☐ Yas 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade compiated)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7		wharehouseman	lumber co.

17. Father's Nama (First, Middla, Last)	18. Mother's Nama (First, Middla, Maidan Surname)
Jacob F. Stull	Etta Florence Hawk

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)
Richard B. Stull (Son)	8997 Kay St., Frederick, Md. 21702

20a. Mathod of Disposition	20b. Placa of Disposition (Nama of camatary, cramatory or othar placa)	Data	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other (Specify)	Reformed Cemetery	5/13	Middletown, Md.

21. Signature of Funeral Service Licensee: Donald B. Thompson

22. Name and Address of Facility: Donald B. Thompson Funeral Home, 31 E. Main St., Middletown, Md. 21769

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that caused tha daath. Do not enter tha mode of dying, such es cardiec or respiretory arrest, shock, or haart failura. List only ona causa on aach lina.

		Approximate Interval Between Onset and Death
Immediata Causa (Final diseasa or condition resulting in death) a.	CVA	1 wk
Dua to (or as a consaquanca of):		
Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Ceusa (Diseasa or Injury that initiated avants resulting in death) Last b.		
Dua to (or as a consequance of):		
c.		
Dua to (or as a consequanca of):		
d.		

Part ii. **Othar significant conditiona** contributing to death but not rasulting in tha undarlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Ware autopsy findings available prior to completion of cause of death?
1☐ Yas 2☒ No	1☐ Yas 2☒ No

25. Was casa raferrad to medical examinar?	26. Placa of Death (Check only ona)	
1☐ Yas 2☒ No	Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA	Othar: 4☒ Nursing Homa 5☐ Residanca 6☐ Othar (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Placa of injury - At homa, farm, straat, factory, office building, atc. (Specify)	28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☑ **Certifying Physician:** To the best of my knowledga, death occurred at the time, date and placa, and dua to tha causa(s) and manner as stated. 2☐ **Madical Examinar:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at the time, dete end plece, end due to tha cause(s) and mannar statad.

29b. Signature and title of cartifiar	29c. Licensa number	29d. Date signed (Month, Day, Year)
Robert L. Kaufman	D13971	5/12/98

30. Nama and address of parson who completed causa of death (Item 23a) (Type, Print): ROBERT L. KAUFMAN 300 9TH ST. FREDERICK MD 21701

State Registrar

31. Data filed (Month, Day, Yaar)	32. Registrar's Signature
MAY 12 1998	Sylvia Theodore Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16138

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES AYDELOTTE SHOCKLEY

2. Date of Death: Month 5 Day 13 Year 98

3. Time of Death: 7:42 AM

4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 216-14-9684

6. Sex: [X] 1 M [ ] 2 F

7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 3-24-12

9. Birthplace *(State or Foreign Country)*: SnowHill, Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Worcester

10c. City, Town or Location: Snow Hill

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7027 Mt. Olive Church Road

10f. Zip Code: 21863

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: farmer

16b. Kind of Business/Industry: own farm

17. Father's Name *(First, Middle, Last)*: Thomas Walter Shockley

18. Mother's Name *(First, Middle, Maiden Surname)*: Naomi L. Figgs (Shockley)

19a. Informant's Name/Relationship *(Type, Print)*: Indiana Shockley (daughter-in-law)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 7007 Mt. Olive Church Rd., Snow Hill, MD. 21863

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Olive Cemetery

Date: 5/16/98

20c. Location - City or Town, State: Snow Hill, Md.

21. Signature of Funeral Service Licensee: Patricia L. Dennis

22. Name end Address of Facility: Dennis Funeral Home, P.O. Box 87, Snow Hill, Md. 21863

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. myocardial infarction — 24 hrs

Due to (or es e consequence of):
b. coronary artery disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

Due to (or as a consequence of):
c.

Due to (or as a consequenca of):
d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

sepsis

metastatic carcinoma

23b. Did tobacco uas contributa to the cause of death? 1 [ ] Yes 2 [/] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [/] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [/] No

26. Place of Death *(Check only one)*: Hospital: 1 [/] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [/] Neturel, 2 [ ] Accident, 3 [ ] Suicide, 4 [ ] Homicide, 5 [ ] Pending investigation, 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [/] **Certifying Phyalcian:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles B. Silvia Jr MD

29c. License number: D30853

29d. Date signed *(Month, Day, Year)*: 5/13/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Charles B. Silvia Jr MD PRMC

10

State Registrar

31. Dete filed *(Month, Dey, Year)*: MAY 15 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

James Shockley SS# 216-14-9684

WRC
98-2597-013
DONALD R.
STONE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I,27,28a-f per MEO G-759 5/26/98

Certificate of Death

rep

98 16139
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Donald Raymond Stone	MAY 07, 1998	2:50 PM.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SLACKS RD. AND RIDGE RD.	SYKESVILLE	CARROLL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
205-52-4075	1☒M 2☐F	39 Yrs.			Apr. 15, 1959	New York

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Carroll	Sykesville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6570 Macbeth Way	21784	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Carpenter	Construction

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Daniel L. Stone	Marie Ann Favro

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Robin L. Stone (Wife)	6570 Macbeth Way Sykesville, MD 21784

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Carroll Cremation Serv	5/9/98	Hampstead, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Brian A. Haight	HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. DOXEPIN INTOXICATION COMPLICATED BY DROWNING

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☑Yes 2☐No	1☑Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) AT SCENE

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	5/7/98	found at 1:20 P M	1☐Yes 2☒No	Overdose of medication/decedent drowned

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Waterway	Sykesville, Md. Slacks Rd. & Ridge Rd.

29a. Certifier (Check only one) 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	O.C.M.E.	MAY 08, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 11 1998	Julie Anderson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16140

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frank Sultzer
2. Date of Death Month Day Year: May 11, 1998
3. Time of Death: 1:10 am
4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 218-24-8163
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 12 1917
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: WV
10b. County: Mineral
10c. City, Town or Location: Keyser
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 36 South Water Street
10f. Zip Code: 26726
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Master Sergeant
16b. Kind of Business/Industry: U.S. Army

17. Father's Name *(First, Middle, Last)*: Unknown
18. Mother's Name *(First, Middle, Maiden Surname)*: Bridget Mills

19a. Informant's Name/Relationship *(Type, Print)*: Barbara J. Davis Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 47 Arnold Street Keyser, WV 26726

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Potomac Memorial Gardens — Date: May 13 1998
20c. Location - City or Town, State: Keyser, WV 26726

21. Signature of Funeral Service Licensee: Larry R. Rotruck
22. Name and Address of Facility: Rotruck-Smith Funeral Home 85 South Main Street Keyser, WV 26726

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Aspergillus pneumonia — 2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Renal failure, herpes tracheobronchitis, left cerebral infarct

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of certifier: D. Leibman
29c. License number: D 43497
29d. Date signed *(Month, Day, Year)*: May 12th 1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. D. Leibman, Memorial Hospital, Cumberland, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 12 1998
32. Registrar's Signature: Julia Thacker-Burkett

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

FRANK SULTZER 218-24-8163

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16141

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Hazel Elizabeth VanMeter

2. Date of Death (Month, Dey, Year): May 12, 1998

3. Time of Death: 3:18 a.m.

4e. Facility Name *(If not institution, give street and number)*: Memorial Hosptial & Medical Center

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 216-38-1537

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 61 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov 5, 1936

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10e. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 13201 Moores Hollow Road

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Maritel Status: 1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Datas:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* white

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | Collega (1-4or 5+):

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Businass/Industry: Own Home

17. Fether's Neme *(First, Middle, Last)*: Doc Hesper Harman

18. Mother's Name *(First, Middle, Meiden Surneme)*: Mary Violia (Piper)

19a. Informent's Neme/Raletionship *(Type, Print)*: Tracy E. VanMeter--son
Tracy E. VanMeter Sr.—husband

19b. Mailing Address *(Street end Numbar or Rural Routa Number, City or Town, Stete, Zip Code)*: 21 Boone Street Cumberland, MD 21502

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Nema of cemetery, crematory or othar place)*: Restlawn Memorial Gardens

Dete: 05/15

20c. Location - City or Town, State: LaVale, MD

21. Signeture of Funarel Service Licensee: Nicholas J Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part1. Enter the diseese, or complications thet ceused the death. Do not anter the mode of dying, such es cerdiac or raspiretory errest, shock, or haert failure. List only one cause on aach line.

Approximata Intervel Between Onset end Death

Immediata Ceuse (Finel diseese or condition resulting in daeth)

a. Intraabdominal sepsis — 1 month

Dua to (or es e consequence of):

b. Mesenteric vascular ischemia — 2 months

Sequentially list conditions, if eny, leeding to immediate ceusa. Entar Underlying Ceuse (Disaase or Injury thet initieted evants resulting in daeth) Lest

Dua to (or es e consequance of):

c. Diffuse atherosclerosis — 5 years

Due to (or es e consaquence of):

d. Insulin-dependent diabetes mellitus — 20 years

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Chronic renal failure, metabolic encephalopathy

23b. Did tobacco use contribute to the cause of deeth? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of ceuse of daath? 1☐ Yas 2☒ No

25. Was cese refarrad to medical examiner? 1☐ Yas 2☒ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA | Othar: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At homa, farm, streat, fectory, office building, etc. *(Specify)*

28f. Location *(Streat and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et tha time, deta and place, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of exemination and/or investigetion, in my opinion, daeth occurred at tha tima, data end piece, and dua to the ceusa(s) end manner stated.

29b. Signeture end title of certifier: N. A. Ranjithan

29c. License number: D 19318

29d. Date signed *(Month, Dey, Year)*: May 14th, 1998

30. Nama and eddress of person who completed cause of death (Item 23a) (Type, Print): N. Ranjithan, M.D., 517 Oldtown Road, Cumberland, MD 21502

State Registrar

31. Dete filed *(Month, Day, Yaar)*: MAY 14 1998

32. Registrar's Signature

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Hazel Vanmeter
216-38-1537
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16142

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Guy Bernard Walter, Sr.

2. Date of Death (Month, Day, Year): May 8, 1998

3. Time of Death: 9:10 AM

4a. Facility Name (If not institution, give street and number): Citizens Nursing Home

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 218-30-4151

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 25, 1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1900 Rosemont Avenue

10f. Zip Code: 21702

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer

16b. Kind of Business/Industry: Farming

17. Father's Name (First, Middle, Last): Elmer Walter

18. Mother's Name (First, Middle, Maiden Surname): Agnes Austin

19a. Informant's Name/Relationship (Type, Print): Guy B. Walter, Jr., Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4883 Blue Spruce Lane, Frederick, MD 21703

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mount Olivet Cemetery, May 11, 1998

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Richard E. Graf M00255

22. Name and Address of Facility: Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Coma — 2 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R. L. Kaufmann

29c. License number: D 13971

29d. Date signed (Month, Day, Year): May 8, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert L. Kaufmann MD 300 West Ninth Street, Frederick, Maryland 21701

State Registrar

31. Date filed (Month, Day, Year): MAY 11 1998

32. Registrar's Signature: Julia Strawbridge Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16143

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CLIFFORD DONALD WILLARD
2. Date of Death Month Day Year: MAY 7, 1998
3. Time of Death: 2:00am
4a. Facility Name *(If not institution, give street and number)*: 4901 FOXVILLE RD.
4b. City, Town, or Location of Death: FOXVILLE
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 219-12-0469
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 27, 1902
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: FREDERICK
10c. City, Town or Location: FOXVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4901 FOXVILLE RD
10f. Zip Code: 21780
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TIMBER MAN
16b. Kind of Business/Industry: SAWMILL

17. Father's Name *(First, Middle, Last)*: WILLIAM KELLY WILLARD
18. Mother's Name *(First, Middle, Maiden Surname)*: ANNIE MARIA HAUVER

19a. Informant's Name/Relationship *(Type, Print)*: JESSE C. WILLARD (SON)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4901 FOXVILLE RD., FOXVILLE, MD 21780

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MT. BETHEL CEMETERY
Date: 5/9/98
20c. Location - City or Town, State: FOXVILLE, MARYLAND

21. Signature of Funeral Service Licensee: Robert E. Dailey
22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN ST., THURMONT, MD 21788

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial infarction — Seconds
Due to (or as a consequence of): b. ASCVD — Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D17549
29d. Date signed *(Month, Day, Year)*: 5/8/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM F. HARPER, M.D. 100 S. CENTER ST., THURMONT, MD 21788

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 11 1998
32. Registrar's Signature:

DHMH t6 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16144

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sarah Wright Ward
2. Date of Death Month/Day/Year: May 10, 1998
3. Time of Death: 2:45AM
4a. Facility Name (If not institution, give street and number): Bradford Oaks Nursing Home
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 123-18-3739
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Dey, Year): Feb. 9,1914
9. Birthplaca (Stata or Foreign Country): New York

Usuel Residance of Decedent

10a. Stata: Maryland
10b. County: Prince George's
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 6709 Stanton Road
10f. Zip Code: 20784
10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Raca - American Indian, Black, White, etc. Specify: White

15. Decadent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+): N/A
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Bookbinder
16b. Kind of Business/Industry: Government Printing Office

17. Fathar's Name (First, Middle, Last): Charles Wright
18. Mother's Neme (First, Middle, Meiden Surneme): Emmagean Wright

19a. Informant's Name/Relationship (Type, Print): Donald G. Ward (Son)
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Steta, Zip Code): 6709 Stanton Road Hyattsville, Maryland 20784

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donetion 5☐ Other (Specify)
20b. Placa of Disposition (Neme of cemetery, cremetory or other place): Cedar Hill Cemetery | Date: May 14, 1008
20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Nama and Addrass of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 20735

Physician /Medical Examiner

23e. Part I. Entar the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiretory arrest, shock, or heart failura. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	CORONARY ARTERY DISEASE	> 1 MONTH
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last b.	CEREBROVASCULAR DISEASE	> 1 MONTH
Due to (or es e consequence of):		
c.		
Due to (or es a consequence of):		
d.		

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.: CARDIAC ARRHYTHMIA

23b. Did tobacco usa contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of causa of death? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)
27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and placa, end due to the cause(s) end manner es stated. 2☐ **Medical Examinar**: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date end place, end due to the cause(s) and mannar stated.

29b. Signature and title of certiar: RB Samtani MD
29c. License number: D27744
29d. Date signed (Month, Dey, Year): 5-11-98

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): RAJ SAMTANI MD 9131 PISCATAWAY RD CLINTON

State Registrar

31. Deta filad (Month, Dey, Yeer): MAY 13 1998
32. Registrar's Signature: Julia Gardner-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by tha attending physician and completely filled in by tha funeral director, page 2 should be detached for usa as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Preston Wise

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#8, E.T. 5/13/98, WCHD

Certificate of Death

Reg. No. 98 16145

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Preston Wise Jr.

2. Date of Death: Month 5 Day 9 Year 98

3. Time of Death: 9:40 PM

4a. Facility Name (If not institution, give street and number): Hartley Hall Nursing Home

4b. City, Town, or Location of Death: Pocomoke md.

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 218-40-7385

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2-8-~~42~~

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md. | 10b. County: Worcester | 10c. City, Town or Location: Pocomoke City, Md. | 10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 506 5th Street | 10f. Zip Code: 21851 | 10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elamantery/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Machine Operator

16b. Kind of Business/Industry: Lumber Co.

17. Fether's Neme (First, Middle, Last): Preston Wise

18. Mother's Nama (First, Middle, Malden Surname): Virginia Jones

19a. Informent's Name/Relationship (Type, Print): Elnora Wise (sister)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 712 9th Street Pocomoke City, md. 21851

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Nema of cemetery, cremetory or other place): Mt. Sinai Cemetary | Dete: 5-16-98

20c. Location - City or Town, State: Pocomoke, Md, 21851

21. Signature of Funeral Service Licensee

22. Neme end Address of Facility: Bennie Smith Funeral Home P.O. Box 331 Pocomoke Md. 21851

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final diseese or condition resulting in deeth) e.	Metastatic Carcinoma of Esophagus	1 month
Due to (or es e consequence of): b.	Carcinoma of Left Lung	2 yrs
Sequentielly list conditions, if any, leeding to Immediete cause. Enter Underlying Ceuse (Diseesa or Injury thet initieted events resulting in deeth) Lest — Due to (or as e consequence of): c.		
Due to (or as e consequenca of): d.		

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

Anemia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yee 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings avellable prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

28. Place of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Mennar of Deeth: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determinad

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end mennar steted.

29b. Signature and title of certifier: Gregorio M. Belloso M.D.

29c. License number: D29505

29d. Dete signed (Month, Dey, Year): 5-11-98

30. Neme and address of person who completed causa of deeth (Item 23e) (Type, Print): GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801

State Registrar

31. Dete filed (Month, Day, Year): MAY 13 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16146

Jesse C. Willison

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JESSE CARL WILLISON
2. Date of Death (Month, Day, Year): May 12, 1998
3. Time of Death: 9:00 am
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-36-6234
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG 21, 1936
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [ ] Yes 2 [ ] No XX
10e. Street and Number: 4 MARICE CIRCLE
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: WHITE

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondery (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): LUMBERMAN
16b. Kind of Business/Industry: LUMBERING

17. Father's Name (First, Middle, Last): CARL L. WILLISON
18. Mother's Neme (First, Middle, Maiden Surname): SUSAN R. JEWELL

19a. Informant's Name/Relationship (Type, Print): CHERYL GLASS/ DAUGHTER
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2822 PENNSYLVANIA AVENUE, BALTIMORE, MD 21227

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): COMPS CEMETERY
Date: MAY 16, 1998
20c. Location - City or Town, State: RD, HYNDMAN, PA 15545

21. Signature of Funeral Service Licensee: Harvey H Zeigler
22. Name and Address of Facility: HARVEY H. ZEIGLER FUNERAL HOME 169 CLARENCE ST, HYNDMAN, PA 15545-0636

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finai disease or condition resulting in death) a.	Recurrent Flash Pulmonary Edema	18 Hours
Due to (or as a consequence of): b.	Ischemic Cardiomyopathy	1 Week
Sequentiaily iist conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Severe Coronary Artery Disease	
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypotension
Cerebrovascular Accident
Chronic Renal Insufficiencies

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Wes cese referred to medicei examiner? 1 [ ] Yes 2 [X] No
26. Piece of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piace of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medicat Examiner:** On the basis of examination and/or Investigation, in my opinion, death occurred et the time, dete and piace, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D
29c. License number: D38754
29d. Date signed (Month, Day, Year): May 12, 1998

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print): Malika Waseem M.D. 9000 Franklin Square Drive Baltimore, MD 21237

State Registrar

31. Date filed (Month, Day, Year): MAY 14 1998
32. Registrar's Signature:

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16147

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wilma Ethel White
2. Date of Death Month Day Year: MAY 1 1998
3. Time of Death: 2:45 PM
4a. Facility Name (If not institution, give street and number): MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 235-40-2398
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 25 1917
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10e. Stete: WV
10b. County: Mineral
10c. City, Town or Location: Burlington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: Rt 1, Box 261 AA
10f. Zip Code: 26710
10g. Citizen of What Country?: U.S.A.

11. Marital Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decadent of Hispanic Crigin? (Specify Yes or No- If Yes, spacify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook
16b. Kind of Business/Industry: Public Schools
17. Father's Name (First, Middle, Last): Emory Pitzer
18. Mother's Name (First, Middle, Maiden Surname): Marie Hodgkiss
19a. Informant's Name/Reletionship (Type, Print): Hanford W. White Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): Rt 1, Box 261 AA Burlington, WV 26710
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Placa of Disposition (Neme of cemetery, crematory or other piece): Shinnston Masonic Cemetery
Date: May 4, 1998
20c. Location - City or Town, State: Shinnston, WV
21. Signature of Funeral Service Licensee: Craig Rotruck
22. Name end Address of Facility: Rotruck-Smith Funeral Home, 85 South Main Street Keyser, WV 26726

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in deeth) a.	acute respiratory failure 2° ARDS	7 days
Due to (or es e consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet Initieted events resulting in death) Last b.		
Due to (or as e consequenca of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes an eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings aveileble prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) end manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: N. McCullough
29c. License number: D 44712
29d. Date signed (Month, Day, Year): 5/8/98

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): NANNETTE MCCULLOUGH M.D., 921 SETON DRIVE, SUITE C, CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Dey, Year): MAY 12 1998
32. Registrar's Signature

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WILMA WHITE 235-40-2398
Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16148

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Jack	F.	Anderson	May 22, 1998	2:00 pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6501 Kenwood Ave.	ROSEDALE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
412285524	1 X M 2 ☐ F	75 Yrs.			AUG 26, 1922	TENNESSEE

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	ROSEDALE	1 ☐ Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6501 KENWOOD AVENUE	21237	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates: WW II	1 ☐ Yes 2 X No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	ELECTRICIAN	STEEL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOHN ANDERSON	ESTELLE SAMA

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
LORENE ANDERSON / WIFE	6501 KENWOOD AVE ROSEDALE, MD 21237

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	PARKWOOD	5/25/98	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTO, MD 21237

Physician /Medical Examiner

23a. Part I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARDIAC FAILURE	one day
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. SMALL CELL CARCINOMA OF LUNG	2 months
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Recent acute myocardial infarction

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown	1 ☐ Yes 2 X No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D04493	May 22, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALCOLM S. DRUSKIN, M.D. KAISER PERMANENTE 4920 CAMPBELL BLVD WHITEMARSH, MD 21236

State Registrar	31. Date Filed (Month, Day, Year)	32. Registrar's Signature
	MAY 26 1998	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16149

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLEMSON AYE
2. Date of Death (Month, Day, Year): May 19, 1998
3. Time of Death: 9:10 pm
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 249-26-1861
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-13-19
9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3919 Kenyon Avenue
10f. Zip Code: 21213
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yas, Giva Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Utility Person
16b. Kind of Business/Industry: Bethlehem Steel Co.

17. Father's Name (First, Middle, Last): Daniel Aye
18. Mother's Name (First, Middle, Maiden Surname): Alice Caldwell

19a. Informant's Name/Relationship (Type, Print): Luvenia Aye
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3919 Kenyon Avenue Baltimore, Md. 21213

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Md. Nat'l Mem. Pk. Cem. Date: 05-26-98
20c. Location - City or Town, State: Laurel, Md.
21. Signature of Funeral Service Licensee: Debra M Davis
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — hours

Dua to (or as a consequence of):

Sequentielly list conditions, if any, leading to immediate ceusa. Enter Underlying Causa (Disease or Injury that initiated evants rasulting in death) Last
b. UTI and Decubiti — days-months

Dua to (or es e consequence of):
c. Dementia — years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uss contributs to ths cause of death? 1 [ ] Yss 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of ceuse of deeth? 1 [ ] Yas 2 [X] No

25. Was case referred to medical exeminer? 1 [X] Yes 2 [ ] No

26. Plece of Daath (Check only ona)
Hospitel: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)
28f. Location (Streat and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledga, death occurred at tha tima, data and place, end due to the ceuse(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of exeminetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: C.N. Schoenfeld
29c. License number: D 23533
29d. Date signed (Month, Day, Year): May 24, 1998

30. Name and address of parson who completed causa of daath (Item 23a) (Type, Print): C.N. Schoenfeld, MD JHBMC 4940 Eastern Ave Baltimore, MD 21224

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Yeer): MAY 26 1998
32. Registrar's Signeture: Lisa Davidson-Randall

DHMH 16 Rev 6/95

MR# 10-33-37

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16150

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ruby Doris Arnold
2. Data of Death Month / Day / Year: May 24 1998
3. Time of Death: 14:38
4a. Facility Name *(If not institution, give street and number)*: Carroll County General Hospital
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 213 - 26 - 1179
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 69 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: March 9, 1929
9. Birthplece *(Steta or Foreign Country)*: N.C.

Usuel Residence of Decedent

10a. Stata: Md
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 2339 Neudecker Rd.
10f. Zip Code: 21157
10g. Citizen of What Country?: U.S.A.

11. Marital Stetus: 1☐ Naver Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretery
16b. Kind of Business/Industry: Manufacturing

17. Father's Name *(First, Middle, Last)*: Daniel Bedsole
18. Mother's Name *(First, Middle, Meiden Surnema)*: Minnie Peterson

19a. Informent's Neme/Relationship *(Type, Print)*: Roy L. Arnold, Sr. Husband
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 2339 Neudecker Rd. Westminster, Md. 21157

20a. Method of Disposition: 1☒ Buriel 2☐ Crametion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, cremetory or other piece)*: Evergreen Memorial — Date: 5/27/98
20c. Location - City or Town, Steta: Finksburg, Md

21. Signatura of Funeral Service Licensee: ▶ [signature]
22. Name end Address of Facility: 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, Md. 21136

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in deeth) e.	Acute Anterior Myocardial Infarction	1 Day
Due to (or es e consequence of):		
Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Lest b.	Cerebral Hemorrhage	1 Day
Due to (or es e consequence of):		
c.		
Due to (or es e consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings availeble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Placa of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete and piece, end due to the cause(s) end menner stated.

29b. Signeture end title of certifier: ▶ Lisa Kim, MD
29c. Licensa number: D0052479
29d. Data signed *(Month, Day, Year)*: May, 24, 1998

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): Lisa Kim, MD Carroll Co Gen Hospital, Memorial Ave. Westminster, Md 21157

State Registrar

31. Date filed *(Month, Dey, Year)*: MAY 26 1998
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Merylend Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial transit

ARNOLD, Ruby Doris

To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 16151

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bonnie Alder

2. Date of Death Month / Day / Year: MAY 21 1998

3. Time of Death: 6:45 AM

4a. Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 093-46-7568

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 58 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 1, 1939

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 109 Janelin Drive

10f. Zip Code: 21061

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Realtor

16b. Kind of Business/Industry: Real Estate

17. Father's Name *(First, Middle, Last)*: Unknown

18. Mother's Name *(First, Middle, Maiden Surname)*: Unknown

19a. Informant's Name/Relationship *(Type, Print)*: Howard D. Alder

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 109 Janelin Drive Glen Burnie, MD 21061

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc.

Date: May 22

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Mitchell Stallings

22. Name and Address of Facility: Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, Md 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC Obstructive Lung disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. BREAST CANCER

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atrial fibrillation/flutter.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D43977

29d. Date signed *(Month, Day, Year)*: May 21 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anyone.. DELETE.. 301 Hospital Drive, Glen Burnie MD. 21061

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998

32. Registrar's Signature: Julia Davidson Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

BONNIE ALDER

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16152

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Paulene Virginia Bendigo
2. Date of Death Month / Day / Year: May 24, 1998
3. Time of Death: 6:40 AM
4a. Facility Name *(If not institution, give street and number)*: 7805 Fairgreen Road
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-20-4905
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 21, 1921
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7805 Fairgreen Road
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Robert Lenhart
18. Mother's Name *(First, Middle, Maiden Surname)*: UNK. Walker

19a. Informant's Name/Relationship *(Type, Print)*: Howard Bendigo/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5513 Spring Wood Dr. Portsmouth, VA 23703

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc. — Date: 05/26/98
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Primary Ovarian Cancer — 1 month.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: M.D.
29c. License number: D 45390
29d. Date signed *(Month, Day, Year)*: 5/26/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MYO MIN (M.D.) 6830 Hospital Dr. # 206, Baltimore MD 21237

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998
32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16153

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN THOMAS BRADY
2. Date of Death: Month: May Day: 20 Year: 1998
3. Time of Death: 0225
4a. Facility Name (If not institution, give street and number): St. Agnes Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 187-03-2910
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02/15/1918
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: CATONSVILLE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2401 STONEWALL COURT
10f. Zip Code: 21228
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALESMANAGER
16b. Kind of Business/Industry: AUTO AGENCY

17. Father's Name (First, Middle, Last): CHARLES F. BRADY
18. Mother's Name (First, Middle, Meiden Surneme): MARY A. MOUGHAN

19a. Informant's Name/Relationship (Type, Print): JANE E. BRADY/ WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2401 STONEWALL COURT CATONSVILLE, MD 21228

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other pleca): NEW CATHEDRAL CEMETERY
Date: 5/22/98
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: ▶ Phillip Starks
22. Neme end Address of Facility: STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. CereSellar Hemorrhage — 10 hrs

Due to (or as a consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest

b.

Due to (or as a consequence of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Anticoagulation

CereSnovascular Disease

23b. Did tobacco use contribute to the ceuse of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit permit.

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier: ▶ E. K. Shepard
29c. License number: D47484
29d. Date signed (Month, Dey, Year): May 20, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ERIC SHEPARD, MD St. Agnes Healthcare 900 Caton Ave Baltimore, MD

NAME Brady, John

10

State Registrar

31. Date filed (Month, Dey, Year): MAY 26 1998
32. Registrar's Signature: Gloria Jackson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16154

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Herbert C. Ball

2. Date of Death (Month, Day, Year): May 18, 98

3. Time of Death: 10:07 am

4a. Facility Name *(If not institution, give street and number)*: Johns Hopkins Bayview Medical Ctn.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 225-12-3274

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 04-22-22

9. Birthplace *(State or Foreign Country)*: VA

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [ ] No XX

10e. Street and Number: 2433 Francis Street

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yaar or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - Americen Indian, Black, White, atc. *Specify:* Black

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 2nd. Grade | College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: U.S. Merchant

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middla, Last)*: Goldie Fauntleroy

18. Mother's Neme *(First, Middle, Maidan Surnama)*: Elizabeth Ball

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Lennie Ball

19b. Mailing Address *(Straat and Number or Rurel Route Number, City or Town, Stata, Zip Code)*: 2433 Francis Street Baltimore, Maryland 21217

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Place of Disposition *(Nama of camatary, cramatory or othar placa)*: Garrison Forest VA Cem.

Date: 05-22-98

20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: Francis Shea

22. Name and Address of Facility: WM.C. March FH 1101 E. North Avenue Baltimore, Maryland 21202

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immadiata Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

b. CEREBROVASCULAR ACCIDENT

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the ceuse of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Ware autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Chack only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Phyaician**: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examinar**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward Obazee MD

29c. License number: D41430

29d. Date signed *(Month, Day, Year)*: 05:20:98

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Edward Obazee VA MED CENTER FORT HOWARD MD

State Registrar

31. Date filed *(Month, Day, Yeer)*: MAY 26 1998

32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours of death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

6+1

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16155

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Wilbur Claude Brown, Jr.

2. Date of Death — Month: May; Day: 23; Year: 1998

3. Time of Death: 4:00 PM

4a. Facility Name *(If not institution, giva street and number)*: 2306 Chetwood Circle, Apt. #102

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-05-5042

6. Sex: 1☐ M 2☐ F — X

7. Aga *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Dey, Year)*: Dec. 22 1913

9. Birthplace *(Stete or Foreign Country)*: Maryland

Usual Residence ot Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2306 Chetwood Circle, Apt. #102

10f. Zip Code: 21093

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elamantary/Secondary (0-12): 12

College (1-4or 5+): n/a

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use ratired)*: Buyer

16b. Kind of Businass/Industry: John Deere

17. Father's Name *(First, Middle, Last)*: Wilbur Claude Brown, Sr.

18. Mother's Name *(First, Middle, Maiden Surneme)*: Daisy Smiley

19a. Intormant's Name/Relationship *(Type, Print)*: Arlene Campeggi/daughter

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2 Edelweiss Way, Parkton, MD 21120

20a. Method ot Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place ot Disposition *(Nema of cematery, crametory or other piece)*: Dulaney Valley Memorial Gardens — Data: 5/27/98

20c. Location - City or Town, State: Timonium, MD

21. Signatura of Funeral Service Licensee: Victor Lengrand, Jr. — Victor Lengrand Jr.

22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Batween Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequance of):

b. Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events rasulting in daath) Last

Due to (or as a consequence of):

c. Hypertension (chronic)

Due to (or as a consequence ot):

d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part i.

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of daath? 1☐ Yes 2☒ No

25. Was casa raferrad to medical examinar? 1☐ Yes 2☒ No

26. Placa of Daath *(Check only one)*

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residance 6☐ Other *(Specify)*

27. Manner of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be determined

28a. Data of Injury *(Month, Dey Year)*

28b. Time ot Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, etc. *(Specify)*

28t. Location *(Street end Number or Rurel Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician:** To tha best of my knowledga, death occurred at the time, data and place, and due to the cause(s) end mannar as etated. 2☐ **Medical Examiner:** On the basis ot axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29b. Signatura and title of certitier: Raymond W. Wilson, M.D.

29c. Licensa number: D41476

29d. Data signad *(Month, Day, Year)*: May 26, 1998

30. Name and addrass of person who completed causa ot daath (Item 23e) (Type, Print): Raymond W. Wilson, M.D. 6565 N. Charles St., Suite 416, Balto., MD 21204

State Registrar

31. Date filed *(Month, Dey, Year)*: MAY 26 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that tha death certificate be exacuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16156

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jennie L Bailey

2. Date of Death: Month May Day 20 Year 1998

3. Time of Death: 20:44pm

4a. Facility Name (If not institution, give street and number): Mercy Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: City N/A

Funeral Director

5. Social Security Number: 212-03-1218

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11/08/1916

9. Birthplace (State or Foreign Country): S. Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 716 Reservoir Street

10f. Zip Code: 21217

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexicen, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): 2

16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired): Receptionist

16b. Kind of Business/Industry: Grant A Wish Foundation

17. Father's Neme (First, Middle, Last): David Wise

18. Mother's Name (First, Middle, Meiden Surname): Illinois Wise

19a. Informant's Name/Relationship (Type, Print): Horace G. Bailey

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 716 Reservoir Street, Balto., MD 21217

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Date: 5/25/98

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Leroy O. Dyett

22. Name and Address of Facility: LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE.,BALTO.,MD21207

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. Sepsis — 24 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pneumonia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: coronary artery disease

23b. Did tobacco uas contributa to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Phyeician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: ▶ Karen A Korzick, MD

29c. Licansa number: D40744

29d. Date signed (Month, Day, Year): May 20, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K. Korzick, M.D. Mercy Hospital 301 St. Paul Place Baltimore, MD 21201

State Registrar

31. Date filed (Month, Dey, Year): MAY 26 1998

32. Registrar's Signature: Julie Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16157

Certificate of Death

Reg. No.

Merle Gertrude Babb
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MERLE GERTRUDE BABB
2. Deta of Deeth: Month May, Dey 18, Year 98
3. Time of Deeth: 5:45 PM
4a. Facility Name (If not institution, giva street and number): DEATON NURSING HOME & SPECIALTY HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-28-5306
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Year): FEB 13, 1932
9. Birthplece (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Insida City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 1019 Tiffany Court
10f. Zip Code: 21201
10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Navar Merriad 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedant Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completad): Elementary/Secondary (0-12): 11th grade; College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): DIETICIAN
16b. Kind of Business/Industry: SALVATION ARMY

17. Fethar's Nama (First, Middle, Last): CHARLES ALTON COLBOURN
18. Mother's Name (First, Middle, Meiden Sumame): HELEN TOLSON

19a. Informent's Name/Relationship (Type, Print): MARIE ARMSTRONG / DAUGHTER
19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code): 21212 1022 EVESHAM AVE BALTIMORE, MARYLAND
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Ramovel from State 4☐ Donation 5☐ Other (Specify)
20b. Plece of Disposition (Neme of cemetery, cremetory or other piece): MT. CALVARY CEMETERY
Dete: 5-23-98
20c. Location - City or Town, State: BROOKLYN MARYLAND
21. Signeture of Funeral Service Licensee: Jerry Hawkins
22. Neme end Address of Facility: CHATMAN - HOWE FUNERAL HOME 5240 REISTERSTOWN ROAD BALTIMORE, MD 21215

Physician /Medical Examiner

23a. Part I. Enter the disease or complications thet ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximete Interval Between Onset end Deeth
Immediete Cause (Finel disease or condition resulting in death) e.	Acute myocardial infarction	Acute
Due to (or es a consequence of):		
Sequentielly list conditions, if eny, leeding to Immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last b.	Generalized Atherosclerotic Cardio Vascular disease	5yrs
Due to (or es a consequance of):		
c.		
Due to (or es a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Diabetes Mellitus, Peripheral Vascular disease, Surgical Wounds / pressure Sores, renal failure, Cerebro Vascular accedent

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveilable prior to compietion of causa of deeth? 1☐ Yes 2☒ No

25. Wes cese referred to medical exeminer? 1☐ Yes 2☒ No
26. Plece of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Deeth: 1☐ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Straet end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end manner stated.
29b. Signatura and titie of certifiar: James F. G. Flynn
29c. License number: DO 1346
29d. Date signed (Month, Dey, Year): May 18 1998
30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): James Flynn MD Deaton Specialty Hospital 611 South Charles St Baltimore Md 21230

State Registrar

31. Dete filed (Month, Dey, Year): MAY 26 1998
32. Registrar Signature: Julia Davidson-Randall

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

98 16158

State of Maryland / Department of Health and Mental Hygiene

Item#19a per FH G759 5/26/98 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY E. BROWN

2. Date of Death Month: MAY Day: 18TH Year: 1998

3. Time of Death: 2:45pm

4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-34-8939

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Oct 23, 1915

9. Birthplaca *(State or Foraign Country)*: NEW YORK

Usual Rasidance of Dacedent

10a. Stata: Maryland

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Insida City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5313 WABASH AVE

10f. Zip Coda: 21215

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Marriad 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Dacadant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Dacadant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Spacify:*

14. Race - Amarican Indian, Black, White, atc. *Specify:* Black

15. Dacadant's Education *(Specify only highast grada compiatad)*: Elementary/Secondary (0-12): 9th GRADE; Collaga (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT usa retired)*: HOUSEKEEPER

16b. Kind of Businass/Industry: Private family

17. Fathar's Nama *(First, Middla, Last)*: UNK. HERNANDAZ

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: MAUDE JEFFRIES

19a. Informant's Name/Relationship *(Type, Print)*: MARION ~~Edmondson~~ Edmondson daughter

19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 5313 WABASH AVE BALTIMORE, Md 21215

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cematery, cramatory or other placa)*: Mt. Lion Cemetery

Data: 5-22-98

20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signatura of Funaral Sarvica Licansaa: Gary Harris

22. Nama and Address of Facility: CHATHAM-HARRIS F.H. 5240 REISTERSTOWN ROAD BALTIMORE MARYLAND 21215

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that causad tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximate Interval Between Onset and Daath

Immediate Causa (Final disaasa or condition rasulting in daath)

a. marked hypotension — >5days

Due to (or as a consequence of):

b. gastrointestinal bleeding — 9days

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or injury that initiatad avants rasulting in daath) Last

Due to (or as a consequance of):

c. Coumadin toxicity — 9days

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha underlying causa given in Part I: Chronic atrial fibrillation; history of dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yas 2☑ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Daath *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Placa of Injury - At home, farm, straat, factory, offica building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☑ **Certifying Phyaician:** To tha bast of my knowladga, daath occurrad at tha tima, data and placa, and due to the causa(s) and manner as stated. 2☐ **Medical Examinar:** On tha basis of examination and/or invastigation, in my opinion, daath occurrad at the time, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of certifier: Danielle Pritchett, MD

29c. Licansa number: AS2402321 DP9287

29d. Data signed *(Month, Day, Year)*: May 18, 1998

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): Danielle D. Pritchett, MD 2401 West Belvedere, Baltimore, MD

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 26 1998

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 16159

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VERA E. BAYKOWSKI
2. Date of Death: Month MAY Day 24 Year 1998
3. Time of Death: 8:25 AM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

Funeral Director

5. Social Security Number: 215-22-0079
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 70 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 25, 1927
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: Md
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1510 Riverside Avenue
10f. Zip Code: 21230
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Willard Parker
18. Mother's Name (First, Middle, Maiden Surname): Helen Maud Cox

19a. Informant's Name/Relationship (Type, Print): Gary P. Baykowski / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1427 E. Clement Street, Baltimore MD 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery — Date: May 28, 1998
20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.
22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC CANCER OF THYROID	2 YRS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: NON INSULIN DEPENDENT DIABETES MELLITUS, HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Chawla (RESIDENT)
29c. License number: AS-2441614.
29d. Date signed (Month, Day, Year): MAY, 24, 1998.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR JASVINDER CHAWLA, HARBOR HOSPITAL CENTER, BALTIMORE, MD 21225.

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16160

Certificate of Death

Reg. No.

BHATTI - KHURSHID

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KHURSHID BHATTI

2. Date of Death (Month, Day, Year): MAY 23 1998

3. Time of Death: 9:32 AM

4a. Facility Name (If not institution, give street and number): 301 Hospital DRIVE

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 590-16-4205

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 4, 1926

9. Birthplace (State or Foreign Country): India

Usual Residence of Decedent

10e. State: Md.

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1 ☐ Yes 2 ☐ No

10e. Street and Number: 366 Monticello Court

10f. Zip Code: 21061

10g. Citizen of What Country? PaKistan

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th grade

College (1-4or 5+): 4 years

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Government Worker

16b. Kind of Business/Industry: Railway

17. Father's Name (First, Middle, Last): Mohammad A. Bhatti

18. Mother's Name (First, Middle, Maiden Surname): Karmuni Sa

19e. Informant's Name/Relationship (Type, Print): AKram Bhatti /Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 366 Monticello Court Glen Burnie, Md. 21061

20e. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Laker Mandi Multan

Date:

20c. Location - City or Town, State: PaKistan

21. Signature of Funeral Service Licensee: ▶ Gladys Wanas

22. Name and Address of Facility: William C. March F/H West 4320 Wabash Ave Baltimore, Md. 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Hemolytic Anemia — 2 days

Due to (or as a consequence of):

b. Possible Sepsis — 2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary edema & Cardiovascular Collapse

End Stage renal disease on Chronic dialysis

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year): N/A

28b. Time of Injury: N/A AM

28c. Injury at Work? 1 ☐ Yes 2 ☐ No N/A

28d. Describe how injury occurred: N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State): N/A

29e. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Bayinnah Shabazz MD

29c. License number: D24592

29d. Date signed (Month, Day, Year): May 23, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bayinnah Shabazz MD 1406B Crain Hwy Ste 206 Glen Burnie Md.

State Registrar

31. Date Filed (Month, Day, Year): MAY 26 1998

32. Registrar Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16161

CLARK WILLIAM

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William L. Clark, Jr.

2. Date of Death (Month, Day, Year): MAY 23, 1998

3. Time of Death: 6:30 AM

4a. Facility Name (If not institution, give street and number): Stella Maris @ Mercy Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-54-0749

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 48 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN 3, 1950

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 705 Aldworth Drive

10f. Zip Code: 21222

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Driver

16b. Kind of Business/Industry: Trucking Industry

17. Father's Name (First, Middle, Last): William L. Clark, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Margie Troy Patton

19a. Informant's Name/Relationship (Type, Print): Bobbie Jo Cotton/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7924 Lynch Rd. Baltimore, MD 21222

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, cramatory or other place): Metro Crematory, Inc. Date: 5/23/98

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): e. METASTATIC CARCINOMA (SQUAMOUS CELL) — 18 MONTHS

Due to (or as a consequence of): OF A PILONIDAL CYST

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

b. Due to (or es a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

CHRONIC LUNG DISEASE

OBSTRUCTIVE UROPATHY

SYMPTOMATIC SICK SINUS SYNDROME

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☑ Other (Specify) Hospice

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, death occurred at the time, dete end piece, and due to the ceuse(s) end menner stated.

29b. Signature end title of certifier

29c. License number: D29296

29d. Date signed (Month, Day, Year): MAY 23 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): GERARD M LAUER 901 E. FORT AVENUE BALTIMORE MD 21230

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16162

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Antoinette M. Cimino

2. Date of Death: Month MAY Day 21 Year 1998

3. Time of Death: 750A

4a. Facility Name *(If not institution, give street and number)*: Mariner Health of Bel Air

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 220-42-9129

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 6-13-09

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Rosedale

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6613 Golden Ring Rd.

10f. Zip Code: 21237

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5; College (1-4or 5+): 0

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Dominick DiLegge

18. Mother's Name *(First, Middle, Maiden Surname)*: Maria DeLuzio

19a. Informant's Name/Relationship *(Type, Print)*: Augusta Guerriero/daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5243 Buttermilk Rd. Pylesville, MD 21132

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Most Holy Redeemer

Date: 5-23-98

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Denise S Kelly

22. Name and Address of Facility: Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 21237

Physician Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE — 1 DAY.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dr. Nowakowski MD

29c. License number: DO 8096

29d. Date signed *(Month, Day, Year)*: MAY 21, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR NOWAKOWSKI MD PA 125 N. MAIN ST. BEL AIR, MD 21014

State Registrar

31. Date Filed *(Month, Day, Year)*: MAY 26 1998

32. Registrar's Signature: Lisha Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Antoinette M. Cimino

4

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16163

Certificate of Death

Reg. No.

NAME KNOWN TO PHYSICIAN: COOK, WILLIAM

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last): WILLIAM COOK				2. Date of Death Month/Day/Year: May 16, 1998				3. Time of Death: 2:01 AM
4a. Facility Name (If not institution, give street and number): VA MARYLAND HEALTH CARE SYSTEM				4b. City, Town, or Location of Death: Perry Point				4c. County of Death: Cecil
5. Social Security Number: 141-16-9560	6. Sex: 1 [X] M 2 [ ] F	7. Age (In yrs. last birthday): 72 Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.		8. Date of Birth (Month, Day, Year): JAN 26 1926		9. Birthplace (State or Foreign Country): VIRGINIA
Usual Residence of Decedent								
10a. State: NEW JERSEY	10b. County: ATLANTIC	10c. City, Town or Location: ATLANTIC CITY						10d. Inside City Limits: [X] Yes 2 [ ] No
10e. Street and Number: 1501 NORTH MICHIGAN AVENUE		10f. Zip Code: 08401				10g. Citizen of What Country?: U.S.A.		
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12yrs	College (1-4or 5+): 2yrs	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLAIMS EXAMINER				16b. Kind of Business/Industry: STATE GOVERNMENT		
17. Father's Name (First, Middle, Last): WILLIE COOK				18. Mother's Name (First, Middle, Maiden Surname): EUNICE COOK				
19a. Informant's Name/Relationship (Type, Print): Richard Cook/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12216 McCullagh Ct, Upper Marlboro, MD 20772						
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place): Atlantic City Cemetery		Date: 5-23-98		20c. Location - City or Town, State: Pleasantville, NJ		
21. Signature of Funeral Service Licensee: Hari P. Close		22. Name and Address of Facility: WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE						

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Carcinoma of Colon with Metastasis	6 Months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetic Nephropathy

Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: K A Wadwa

29c. License number: D48268

29d. Date signed (Month, Day, Year): May 16, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KALYAN WADWA, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998

32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16164

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Tyrone E Cobb

2. Date of Death Month: 5 Day: 20 Year: 1998

3. Time of Death: 3:30A

4a. Facility Name *(If not institution, give street and number)*: Genesis Homewood

4b. City, Town, or Location of Death: Balto.

4c. County of Death: NA

Funeral Director

5. Social Security Number: 220-64-3205

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 38 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 05-16-60

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 315 North Stricker Street

10f. Zip Code: 21223

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th Grade; College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Janitorial Work

16b. Kind of Business/Industry: Laborer

17. Father's Name *(First, Middle, Last)*: Milton Cobb, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Pearline Hunter

19a. Informant's Name/Relationship *(Type, Print)*: Pearline Cobb

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 315 N. Stricker Street Baltimore, Md. 21223

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Greenmount Cemetery

Date: 05-23-98

20c. Location - City or Town, State: Baltimore, MD.

21. Signature of Funeral Service Licensee: Vanessa Cobb

22. Name and Address of Facility: Baltimore, Md. 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACQUIRED IMMUNODEFICIENCY SYNDROME

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. HUMAN IMMUNODEFICIENCY VIRUS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

LYMPHOMA.

ENCEPHALOPATHY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: 043945

29d. Date signed *(Month, Day, Year)*: May 20 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HARIS ALEEM, MD 3007 E NORTHERN PARKWAY BALTIMORE, MD 21214

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998

32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Medical Examiner Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

98 16165

1 - FOR STATE REGISTRAR Item:1, per M.D G-759 5/26/98

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH reb

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
~~CHAN TSANG~~ CHUN TSANG		May 21 1998	10:20 A.M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
175-52-1458	1 [X] M 2 [ ] F	74 YRS.			Aug. 23 1923	China

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
North West Nursing Home Center	Baltimore	n/a

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	n/a	Baltimore	1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
4601 Pall Mall Road	21215	China

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: Asian

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5 +)		
12	n/a	Cook	Restaurant

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
King Tsang	Ying Yik

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
David Tsang/Son	2527 Greenmount Ave., Balto., MD 21218

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Dulaney Valley Memorial Gardens	Timonium, MD 21093

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Bryan W. Clary	Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Dilated Cardiomyopathy	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- Chronic Renal insufficiency
-

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
A. Ahmed M.D	D39127	▶ 5/21/98

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
821 Eutaw Street Baltimore MD 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAY 26 1998	Julia Davidson-Randall

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16166

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Shelton Cannon
2. Data of Deeth — Month: May — Dey: 22 — Yeer: 1998
3. Time of Death: 11:50 am
4a. Facility Nema (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 577-28-5754
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): May 17, 1923
9. Birthpiece (State or Foreign Country): North Carolina

Usuel Residenca of Decadent

10a. Stete: MD
10b. County: Anne Arundel
10c. City, Town or Location: Millersville
10d. Inside City Limits: 1 [ ] Yes [X] No

10e. Street and Number: 1606 Millersville Road
10f. Zip Code: 21108
10g. Citizan of Whet Country?: USA

11. Marifal Stafus: 1 [ ] Naver Married 2 [ ] Merried 3 [X] Widowad 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Yaar or Detas:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.): 1 [ ] Yes [X] No — Specify:
14. Raca - Amarican Indian, Bieck, White, etc. — Specify: White

15. Decedent's Education (Specify only highast greda compleated) — Elementery/Secondary (0-12): 12 — College (1-4or 5+):
18a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired): Electrical Engineer
16b. Kind of Business/Industry: John Hopkins Physics Lab

17. Fathar's Nama (First, Middla, Last): Claudius L. Cannon
18. Mother's Neme (First, Middle, Maiden Surname): Ida Edwards

19e. Informant's Name/Reietionship (Type, Print): Shelton M. Cannon, Jr.- Son
19b. Meiling Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code): 1606 Millersville Road, Millersville, MD 21108

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donation 5 [ ] Othar (Spacify)
20b. Piece of Disposition (Name of cemafary, crematory or other pieca): Oleander Memorial Gardens — Dete: 05/26
20c. Location - City or Town, Stata: Wilmington, NC

21. Signature of Funeral Service Licensee: Robert J. Hardesty
22. Name end Address of Feciliity: Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD21041

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Deeth

Immediata Causa (Finei diseese or condition resulting in death)
a. Intracerebral Hemorrhage — 48 hours
Due to (or es a consequence of):
b.
Due to (or es e consequenca of):
Sequentially list conditions, if any, leeding to immadiate causa. Entar Underlying Ceuse (Disease or injury thet initiated events resulting in deeth) Lest
c.
Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Alzheimer's Dementia
Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yee 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Were eutopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Piece of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Othar: 4 [ ] Nursing Homa 5 [ ] Rasidance 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Netural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, fectory, offica building, atc. (Specify)
28f. Location (Street end Number or Rural Routa Numbar, City or Town, Stata)

29a. Certifier (Check only one): 1 [X] **Certifying Phyeician:** To tha best of my knowledga, daath occurred et the time, data end plece, end dua to tha causa(s) and mennar as stated. 2 [ ] **Medical Examinar:** On the basis of examinetion end/or investigation, in my opinion, daath occurred et the time, date and place, and dua to the cause(s) and menner steted.

29b. Signature and title of certifier: Sharon M Messics MD
29c. Licanse number: D4/586
29d. Date signed (Month, Dey, Yaer): 5/22/98

30. Neme and eddress of parson who compiated cause of death (Item 23a) (Type, Print): Sharon M. Messics MD, 180 Aintra Cochrane Drive, Annapolis, MD 21401

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 26 1998
32. Regis[illegible] Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16167

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: NOAH CLARK

2. Data of Daeth: Month: May; Day: 22; Year: 1998

3. Time of Death: 2125

4a. Facility Nama *(If not institution, giva street and number)*: UNIVERSITY OF MARYLAND MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: N/A

6. Sex: 1☒M 2☐F

7. Aga *(In yrs. last birthday)*: Yrs.

If Under 1 Year: Months; Days: 8

If Under 24 Hrs.: Hours: 10; Min.: 40

8. Data of Birth *(Month, Day, Year)*: May 14, 1998

9. Birthplaca *(Stata or Foraign Country)*: Md.

Usual Rasidance of Dacedent

10a. Stata: Md.

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Insida City Limits: 1☐Yas 2☒No

10e. Street and Number: 404 W. Joppa Rd. Apt. 3

10f. Zip Coda: 21204

10g. Citizan of What Country?: USA

11. Maritai Status: 1☒Nevar Married 2☐Married 3☐Widowed 4☐Divorcad

12. Wes Dacedent Evar in U.S. Armed Forcas? 1☐Yas 2☒No If Yas, Giva Yeer or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1☐Yas 2☒No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elamantary/Secondary (0-12): N/A; Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: N/A

16b. Kind of Business/Industry: N/A

17. Fathar's Nama *(First, Middla, Last)*: Unknown Unknown

18. Mothar's Name *(First, Middla, Maidan Sumama)*: Leslie Jane Clark

19a. Informant's Name/Ralationship *(Type, Print)*: Leslie J. Clark/mother

19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 404 W. Joppa Rd. Apt. 3 Towson, Md. 21204

20a. Mathod of Disposition: 1☐Burial 2☒Cramation 3☐Ramoval from Steta 4☐Donation 5☐Othar *(Specify)*

20b. Placa of Disposition *(Nama of camatary, cramatory or othar piace)*: Hilltop Service Corp.

Data: 5/26/98

20c. Location - City or Town, State: Towson, Md.

21. Signatura of Funaral Sarvica Licensaa:

22. Nama and Addrass of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaen Onset and Death

Immediata Causa (Final disaasa or condition resulting in daath)

a. Cardiopulmonary Failure — Approximata Intarval: < 1 hour

Dua to (or as a consequance of):

Sequantially list conditions, if any, laading to immadiata ceuse. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last

b. Hydranencephaly

Dua to (or as a consequanca of):

c.

Due to (or es e consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.: Prematurity

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Wara autopsy findings available prior to compiation of cause of daath? 1☐Yas 2☐No

25. Was cese rafarred to medical examiner? 1☐Yas 2☒No

26. Placa of Daath *(Check only ona)*: Hospital: 1☒Inpatiant 2☐ER/Outpatient 3☐DOA Othar: 4☐Nursing Homa 5☐Rasidance 6☐Other *(Specify)*

27. Mannar of Death: 1☒Naturel 2☐Accidant 3☐Suicida 4☐Homicida 5☐Panding invastigation 6☐Could not ba datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒**Certifying Physician:** To tha bast of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐**Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar statad.

29b. Signatura and titla of cartifiar: ▶ Robert A.L. Blake, M.D.

29c. Licansa number: D47798

29d. Data signed *(Month, Day, Year)*: May 22 1998

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): Robert A.L Blake M.D. 22 S. Greene Street Baltimore MD 21201

State Registrar

31. Data filad *(Month, Day, Year)*: MAY 26 1998

32. Registrar's Signature:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16168

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GORDON F. CHANEY

2. Date of Death: Month: May Day: 20 Year: 1998

3. Time of Death: 9:09PM

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-03-2050

6. Sex: 1 X M 2 F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 8, 1911

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 Yes 2 X No

10e. Street and Number: 824 Woodrow Ave.

10f. Zip Code: 21221

10g. Citizen of What Country? USA

11. Marital Status: 1 Never Married 2 Married 3 X Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yas 2 X No If Yes, Give Yaar or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grade completed): Elementery/Secondary (0-12): 8th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance

16b. Kind of Business/Industry: Arrow Brewing Co.

17. Father's Name (First, Middle, Last): Edward Chaney

18. Mother's Name (First, Middle, Maiden Sumame): unknown

19a. Informant's Name/Relationship (Type, Print): Richard Chaney /son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1725 Belvue Drive Forest Hill Md. 21050

20e. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cematary, cramatory or other placa): Gardens of Faith | Dete: 5/23/98

20c. Location - City or Town, State: Rossville Md.

21. Signature of Funeral Servica Licensee: R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex 300 Mace AVe. Baltimore MD. 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiiure. List only one ceuse on each line. | Approximate Interval Between Onset and Death

Immediete Ceuse (Finei disease or condition resulting in death)

a. fatal Arrhythmia — 5 minutes

Due to (or as a consequence of):

Sequentially iist conditions, if any, leading to immediate cause. Enter Undarlying Ceuse (Diseese or injury that initiated events resulting in death) Last

b. Cardiomyopathy

Due to (or as a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other signiffcant conditions** contributing to death but not rasulting in the undarlying cause givan in Part I.

23b. Did tobacco use contributa to the causa of death? 1 Yas 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Ware autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Wes case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one): Hospitel: 1 X Inpatiant 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residenca 6 Other (Specify)

27. Manner of Death: 1 X Netural 2 Accident 3 Sulcide 4 Homicide 5 Pending investigation 6 Couid not be determined

28a. Dete of injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 **Medical Examinar:** On the basis of axamination and/or investigetion, in my opinion, death occurred at tha tima, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: # RD 187153

29d. Date signed (Month, Day, Year): 5/21/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Carolyn Tabak MD 9000 Franklin Square Dr. Baltimore, MD 21237

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Meryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Gordon Chaney

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16169

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
ROBERT	J.	DALRYMPLE	MAY	19	1998	4:50 am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Good Samaritan Hospital	Baltimore	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
239-24-3010	1☒ M 2☐ F	75 Yrs.			04-18-23	NC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
123 West 29th Street	21218	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.)	14. Race - American Indien, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Giva Year or Dales:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	Collega (1-4or 5+)		
12th Grade	12th Grade	Truck Driver	Mace Produce Co.

17. Father's Name (First, Middle, Last)	18. Mothar's Nama (First, Middle, Maiden Surname)
Beatrice Dalrymple	Annie Lee Sullivan

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21239
Barbara A. Rather	1505 Sherwood Road baltimore, Maryland

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	King Mem. Pk. Cem.	05-22-98	Randallstown, Md.

21. Signeture of Funerel Service Licensee	22. Name end Address of Facility
▶ Vanessa Cox	Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Entar the disaasa, or complications that ceused the daath. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only ona cause on each lina.

		Approximate Interval Between Onset and Death
Immediata Causa (Final diseese or condition resulting in death)	a. Sepsis	2 days
	Due to (or as a consequence of):	
Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disaase or injury that initiated evants resulting in deeth) Lest	b.	
	Due to (or as a consequance of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to daath but not resulting in the underlying cause given in Part I.

Gastrointestinal Bleeding

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were eutopsy findings aveilable prior to completion of cause of death?
1☒ Yes 2☑ No	1☐ Yes 2☑ No

25. Was case rafarrad to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one) 1☑ **Certifying Physician:** To tha bast of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurrad at tha tima, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Michel Skaf, MD	P11391	May 19, 1998

30. Name and address of person who completed ceuse of daath (Item 23a) (Type, Print)

Michel Skaf, Lock Raven Blvd, Baltimore, MD 21239.

State Registrar

31. Data filed (Month, Day, Year)	32. Registrer's Signature
MAY 26 1998	▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16170

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anna C. Dalrymple

2. Date of Death (Month, Day, Year): May 19, 1998

3. Time of Death: 9:37 a.m

4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 223-14-0202

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 02-17-22

9. Birthplace *(State or Foreign Country)*: VA

Usual Residence of Decedent

10a. State: Md

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 123 West 29th Street Apt.#5J

10f. Zip Code: 21218

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Laborer

17. Father's Name *(First, Middle, Last)*: Henry Jackson

18. Mother's Name *(First, Middle, Maiden Surname)*: Marie Jackson

19a. Informant's Name/Relationship *(Type, Print)*: Barbara A. Rather

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1505 Sherwood Road Baltimore, Maryland 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King Mem. Pk. Cem. Date: 05-22-98

20c. Location - City or Town, State: Randallstown, Md.

21. Signature of Funeral Service Licensee: Francis [illegible]

22. Name and Address of Facility: WM.C. March FH 1101 E. North Avenue Baltimore, Maryland 21202

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	24 hrs
Due to (or as a consequence of):	b. E. coli Empycma	1 month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. E. coli pneumonia	2 months
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Accident

morbid obesity

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or Investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated.

29b. Signature end title of certifier: Paul Peña MD

29c. License number: AT 2438946

29d. Date signed *(Month, Day, Year)*: may 19, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Peña 201 East University Parkway Baltimore MD 21218

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998

32. Registrar's Signature: Julia Davidson-Daniels

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death occurs. To the Funeral Director: This certificate has been signed by the attending physician and completely filled in page 1. You should detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Anna C. Dalrymple

4

RKD

98-2918-510

DESMOND JORDAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16171

Items: 23 part I,27 per MEO G-762 8/5/98 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Desmond Marquise Quran Davis	MAY 20,1998	7:10P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
UNIVERSITY HOSPITAL	BALTIMORE	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-49-6171	1☒ M 2☐ F	Yrs.	9		08-08-97	Md.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	NA	Baltimore	1☐ Yes 2☐ No XX

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
806 W. Lexington Street Apt.#6	21201	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
Child	NA	Infant	Child

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Gary Davis, Jr.	Melika Jordan

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Gary Davis, Jr.	2505 N. Rosedale Street Baltimore, Md. 21216

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Arbutus Mem. Pk. Cem.	05-26-98	Arbutus, Md.

21. Signeture of Funeral Service Licensee	22. Name end Address of Feciility
▶ [signature]	Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	
	Due to (or es e consequence of):	
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury thet Initiated events resulting in death) Lest	b.	
	Due to (or es a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part tt. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given In Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was cese referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ ~~Pending~~ Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Phyeician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) end manner es stated.
2☒ **Medical Examiner:** On the basis of examination end/or investigation, In my opinlon, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Donald G. Wright MD	O.C.M.E.	MAY 22,1998

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print)
DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 26 1998	▶ Julia Davidson Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16172

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCIS X. DOOLEY
2. Date of Death Month Day Year: MAY 22, 1998
3. Time of Death: 6:15 A.M.
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 217-01-6300
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7/2/1919
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 300 MAPLE LANE, N.W.
10f. Zip Code: 21061
10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: WWII
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ACCOUNTANT
16b. Kind of Business/Industry: KOPPERS CO.

17. Fether's Neme (First, Middle, Last): MICHEAL DOOLEY
18. Mother's Neme (First, Middle, Meiden Surname): ANNA CORCORAN

19a. Informent's Neme/Relationship (Type, Print): MARY A. DOOLEY - WIFE
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 300 MAPLE LANE, N.W., GLEN BURNIE, MD 21061

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece): MEADOWRIDGE CEMETERY
Dete: 5/26
20c. Location - City or Town, Stete: ELKRIDGE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: RAYMOND C. FINK FUNERAL HOME OF GLEN BURNIE, 426 CRAIN HWY., S.W., GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. — Approximete Interval Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in deeth):
a. Coronary Artery Disease — years
Due to (or as a consequence of):
b. Hypertension — years
Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Lest
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No
26. Plece of Death (Check only one): Hospitel: 1 [ ] Inpetient 2 [X] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date and plece, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: [signature] D19512
29c. License number: D19512
29d. Date signed (Month, Day, Year): 5-22-98

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): SANG C. DO'H MD 1600 CRAIN Highway SUITE 206 GLEN BURNIE MD 21061

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 26 1998
32. Registrer's Signeture: Julia Davidson Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Francis Dooley

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16173

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen H. Dubois
2. Date of Death: Month May Day 22 Year 98
3. Time of Death: 0130 AM
4a. Facility Name (If not institution, give street and number): Lorien-Riverside Nursing & Rehab.
4b. City, Town, or Location of Death: Edgewood
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 132-24-5234
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 30 05
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7232 German Hill Road
10f. Zip Code: 21222
10g. Citizen of What Country?: U.S.of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home Maker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Conrad Hildebrand
18. Mother's Name (First, Middle, Maiden Surname): Maria Moser

19a. Informant's Name/Relationship (Type, Print): Suzanne Wackerman (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 140 Eagle St. Apt. 102 Anchorage, Alaska 99501

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro
Date: May 23
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Mark A Rynick
22. Name and Address of Facility: W. Dabrowski-Chojnacki F.H.'s P.A. 1005 Dundalk Ave. Balto., Md. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Chronic obstructive pulmonary disease 7 year
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D28339
29d. Date signed (Month, Day, Year): May 27, 1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LINDA PUSKULICH 101 E Mead Road Middle River MD 21220

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998
32. Registrar's Signature: [signature] Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Helen H. DuBois

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16174

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Mildred Epps
2. Dete of Death Month: MAY Dey: 21 Year: 1998
3. Time of Death: 514AM
4e. Fecility Neme (If not institution, give street end number): Fallston General Hospital
4b. City, Town, or Location of Deeth: Fallston
4c. County of Deeth: Harford Co.

Funeral Director

5. Sociel Security Number: 214-36-9995
6. Sex: 1☐ M 2☐ F XX
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): 03-23-40
9. Birthplece (Stete or Foreign Country): MD

Usuel Residence of Decedent

10e. Stete: Md
10b. County: Harford
10c. City, Town or Location: Edgewood
10d. Inside City Limits: 1☐ Yes 2☐ No XX
10e. Street end Number: 1941 Edgewater Drive
10f. Zip Code: 21040
10g. Citizen of Whet Country?: USA
11. Meritel Stetus: 1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No XX If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indien, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): High School; College (1-4or 5+): NA
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Cook
16b. Kind of Business/Industry: Blue bell Seafood Co.
17. Fether's Neme (First, Middle, Last): William Cohens
18. Mother's Neme (First, Middle, Maiden Surneme): Mildred Boone
19a. Informent's Neme/Reletionship (Type, Print): James Myers
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 808 Ermine Court Edgewood, Maryland 21040
20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Garrison Forest VA Cem.
Dete: 05-27-98
20c. Location - City or Town, Stete: Md. Owings Mills,
21. Signeture of Funeret Service Licensee: Bernard D Johnson
22. Neme end Address of Fecility: Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on each line.

Approximete Interval Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth)
e. Pulmonary Hemorrhage — 1 day
Due to (or as e consequence of):
b. Recurrent Lung Cancer — 3mo.

Sequentiatly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☑ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Piece of Death (Check only one): Hospitel: 1☐ Inpetient 2☑ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☑ **Certifying Phyeician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medicel Exeminer**: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: MYO MIN (M.D.)
29c. License number: D 45390
29d. Dete signed (Month, Dey, Year): 5/21/98

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): MYO MIN (M.D.), 615 W. MacPhail Rd. #212, Bel Air, MD 21014

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Epps, Mildred Louise
Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed (Month, Day, Year): MAY 26 1998
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

98 16175

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Nettie Edwards
2. DATE OF DEATH (Month, Day, Year): May 19 1998
3. TIME OF DEATH: 4:30 P M
4. SOCIAL SECURITY NUMBER: 217-22-5987
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 82 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): July 26, 1915
8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): North Charles Health Care Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: N/A
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2100 BRADDISH AVENUE
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY? USA.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH GRADE — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FOOD PREPARER
16b. KIND OF BUSINESS/INDUSTRY: PROVIDENT HOSPITAL
17. FATHER'S NAME (First, Middle, Last): JOSEPH FLEMING
18. MOTHER'S NAME (First, Middle, Maiden Surname): CALLIE EDWARDS
19a. INFORMANT'S NAME (Type/Print): FREDDIE G. EDWARDS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4400 VESTA AVENUE, BALTIMORE, MD. 21207
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS CEMETERY — DATE: 5-23-98
20c. LOCATION — City or Town, State: ARBUTUS, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIMORE, MD. 21217

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. End Stage renal disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Raymond Millis MD
29c. LICENSE NUMBER: D47683
29d. DATE SIGNED (Month, Day, Year): ▶ 5/21/98

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Raymond Millis 25 Main Street Suite 200 Reisterstown, MD

31. DATE FILED (Month, Day, Year): MAY 26 1998
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-18 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16176

Certificate of Death

Reg. No.

Amend: #10e,19b Per Informant Film G760 6-5-98RC

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William John Eyring

2. Data of Death Month Day Yaar: May 18, 1998

3. Tima of Death: 9:45 PM

4a. Facility Nama (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217-18-3129

6. Sex: 1 [X] M 2 [ ] F

7. Aga (In yrs. last birthday): 80 Yrs.

If Under 1 Yaar: Months / Deys

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Sept. 1, 1917

9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Dacedant

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Insida City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: ~~1347~~ 1437 Cape St. Claire Road

10f. Zip Coda: 21401

10g. Citizan of What Country?: U.S.A.

11. Maritel Status: 1 [ ] Never Merriad 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U,S. Armed Forces? 1 [X] Yes 2 [ ] No If Yas, Giva Yaer or Datas: 1936-47

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - Amarican Indian, Black, White, atc. Specify: White

15. Decedant's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired): Foreman

16b. Kind of Business/Industry: Gas and Electric

17. Fathar's Nama (First, Middla, Last): Adolph William Eyring

18. Mother's Name (First, Middla, Maiden Sumama): Margaret Weller Amer

19a. Informant's Name/Relationship (Type, Print): Wanda Eyring/wife

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): ~~1347~~ 1437 Cape St. Claire Road, Annapolis, Maryland 21401

20a. Mathod of Disposition: 1 [ ] Burial 2 [ ] Cramation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Nama of cematary, crematory or other piece)

Data

20c. Location - City or Town, Stata

21. Signature of Funeral Service Licensee: Joseph B. Van Sant

22. Nama and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive heart failure — Hours

Due to (or as a consequence of):

b. Ventricular Septal defect — Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Inferior, posterior myocardial infarction — Days

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Angela Calle MD

29c. License number: D41479

29d. Date signed (Month, Day, Year): May 19, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Angela Calle MD 2448 Holly Avenue Annapolis, MD 21401

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16177

EMERSON, MYRON
Baltimore, Maryland 21215-0020

Physician /Medical Examiner | **Funeral Director** | **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): Myron Miller Emerson, Jr.
2. Date of Death (Month, Day, Year): MAY. 21, 1998
3. Time of Death: 3:15 PM
4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER
4b. City, Town, or Location of Death: ROSEDALE
4c. County of Death: BALTIMORE
5. Social Security Number: 220-36-3764
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 57 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 20, 1941
9. Birthplace (State or Foreign Country): Baltimore, MD

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6904 Mornington Road Apt. C
10f. Zip Code: 21222
10g. Citizen of What Country?: United States
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2 Years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Courrier
16b. Kind of Business/Industry: Delivery
17. Father's Name (First, Middle, Last): Myron Miller Emerson, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Martha Louise Benton
19a. Informant's Name/Relationship (Type, Print): Mrs. Michele L. Emerson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6904 Mornington Road Apt. C Dundalk, MD 21222
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Hilltop Service Corp.
Date: 5/26/1998
20c. Location - City or Town, State: Towson, Maryland
21. Signature of Funeral Service Licensee
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner | **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARCINOMATOSIS MENINGITIS — 2 MONTHS
Due to (or as a consequence of):
b. RELAPSED ADENOCARCINOMA OF LUNG — 2 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: D45390
29d. Date signed (Month, Day, Year): 5/21/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MYO MIN (M.D.) 6830 Hospital Dr. #206, Baltimore, MD 21237

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998
32. Registrar's Signature

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16178

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DEVELONE FRONEBERGER

2. Date of Death — Month: MAY Day: 20 Year: 1998

3. Time of Death: 1510

4a. Facility Name *(If not institution, give street and number)*: UMMS

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 218-04-6492

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 42 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: FEB. 16, 1956

9. Birthplace *(State or Foreign Country)*: N. CAROLINA

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1702 ASHBURTON ST.

10f. Zip Code: 21216

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12TH College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: FOOD SERVICE

16b. Kind of Business/Industry: FOOD

17. Father's Name *(First, Middle, Last)*: RICHARD LEE SR.

18. Mother's Name *(First, Middle, Maiden Surname)*: ROMELIA HAWSLEY

19a. Informant's Name/Relationship *(Type, Print)*: THOMAS FRONEBERGER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1702 ASHBURTON ST, BALT, MD. 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MT. ZION

Date: 5/27/98

20c. Location - City or Town, State: LANSDOWNE MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: GARY F. MARCA FUNERAL HOME P.A. 2704 FREDERICK AVE BALT, MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CEREBRAL HERNIATION SYNDROME — 10 HRS

Due to (or as a consequence of):

b. CEREBRAL EDEMA — 10 HRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. SUBARACHNOID HEMORRHAGE — 10 HRS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: P 10252

29d. Date signed *(Month, Day, Year)*: MAY 20, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): COOK, JUDSON H. MD 22 S. GREENE ST, BALTIMORE, MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

ADH
98-2750-510
PEGGY FREEMAN Item: 17 per F.H. G-759 5/26/98 reb

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16179

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PEGGY MARIE FREEMAN
2. Date of Death: Month MAY Day 15 Year 1998
3. Time of Death: 08:25 AM
4a. Facility Name (If not institution, give street and number): 2364 MCCULLOH STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-32-6997
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APRIL 19, 1937
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1743 DARLEY AVENUE
10f. Zip Code: 21213
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DISABILITY SPECIALIST
16b. Kind of Business/Industry: SOCIAL SECURITY ADM.

17. Father's Name (First, Middle, Last): CLARENCE ~~L. COOK~~ BAKER
18. Mother's Name (First, Middle, Maiden Surname): JULETE L. COOK

19a. Informant's Name/Relationship (Type, Print): MELVIN P. FREEMAN (HUSBAND)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1743 DARLEY AVE. BALTIMORE, MARYLAND 21213

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY
Date: 5-16-98
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Joseph H. Brown
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? PENDING 1☑ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No XX
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☑ Other (Specify) IN CAR

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☑ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Margarita Korell
29c. License number: OCME
29d. Date signed (Month, Day, Year): MAY 15, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To be completed by Funeral Director: permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16180

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
ESTHER	FROMM	MAY 21 1998	1 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTH OAKS HEALTH CENTER	BALTIMORE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-18-9645	1☐ M 2☒ F	88 Yrs.			JAN 14, 1910	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
725 MOUNT WILSON LANE, APT. 617	21208	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
NATHAN	KABIK	BESSIE	FISHER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MRS. DARA BUNJON (DAUG.)	828 MILFORD MILL RD. BALTO., MD 21208

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	BETH TFILOH	5/22/98	BALTIMORE, M D

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Congestive Heart Failure	1 week
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	Atherosclerotic Vascular disease	10 yrs
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check Only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] MD	D34675	5/21/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOEL MESHULAM 1147 S HANOVER ST BALT MD 21230

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 26 1998	[signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16181

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*	2. Date of Death Month / Day / Year	3. Time of Death
Doris E. Francis	May 22 1998	10:25 AM

4a. Facility Name *(If not institution, give street and number)*	4b. City, Town, or Location of Death	4c. County of Death
Genesis Eldercare - Heritage Center	Dundalk	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age *(In yrs. last birthday)*	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth *(Month, Day, Year)*	9. Birthplace *(State or Foreign Country)*
215-24-1536	1☐ M 2☒ F	69 Yrs.			Oct 14 1928	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Edgemere	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7 Vagabond Lane	21219	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*		16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*	16b. Kind of Business/Industry
Elamantary/Secondary (0-12)	College (1-4or 5+)		
6		Housewife	Own Home

17. Father's Name *(First, Middle, Last)*	18. Mother's Name *(First, Middle, Malden Surname)*
John Goodwin	Theresa Hubert

19a. Informant's Name/Raiationship *(Type, Print)*	19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*
Richard H. Francis /husband	7 Vagabond Lane Baltimore, MD 21219

20a. Mathod of Disposition	20b. Place of Disposition *(Name of cemetery, crematory or other place)*	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*	Baltimore National	May 26	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Anthony Colt Connelly	Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach line.

		Approximata Intarval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARDIOPULMONARY ARREST	
	Due to (or as a consequenca of):	
Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. METASTATIC COLON CARCINOMA	
	Due to (or as a consequence of):	
	c. CORONARY ARTERY DISEASE	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

23b. **Did tobecco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?
1☐ Yas 2☑ No	1☐ Yes 2☑ No

25. Was case referred to medical examiner?	26. Place of Death *(Check only one)*	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☑ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death	28a. Date of Injury *(Month, Day Year)*	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined		M	1☐ Yes 2☐ No	
	28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*			28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifiar *(Check only one)*: 1☑ **Certifying Physician:** To tha best of my knowledga, death occurrad at tha tima, data and placa, and dua to the causa(s) and mannar as stated. 2☐ **Medicat Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and titia of certifiar	29c. Licansa number	29d. Date signed *(Month, Day, Year)*
▶ Savinder K Julka M.D	D27188	May 22, 1998

30. Name and address of person who completad causa of death (Item 23a) (Type, Print)
Savinder Julka, M.D. 2 Market Place Baltimore, MD 21222

State Registrar

31. Date filed *(Month, Day, Year)*	32. Registrar's Signature
MAY 26 1998	▶ Gina Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

98-2888-013

FREDERICK H, FITCH
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16182

Items:4a,23 part I,II,27 per MEO G-760 6/3/98 rep

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Frederick Hart Fitch	MAY	20	1998	20:30 P

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
807 YOUNG ~~WAY~~ COURT	WESTMINSTER	CARROLL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-42-5458	1☒M 2☐F	54 Yrs.			March 3 1944	Washington,D.C.

Usuel Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	Carroll	Westminster	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
807 Young Court	21158	U.S.A.

11. Marital Stetus	12. Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Yeer or Detes:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grede completed)		16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
	2	executive officer	National Security Agency

17. Fether's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
John A. Fitch	Rebecca Foster

19e. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Hope C. Fitch exwife	1C Winesap Court, Catonsville, Md. 21228

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☒Burial 2☐Cremetion 3☐Removel from State 4☐Donation 5☐Other (Specify)	Lakeview Cemetery	5/26/98	Eldersburg, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Feclity
▶ Sonda L Lemmer	WitzkeFuneral Homes, Inc. 1630 Edmondson Ave., Catonsville, Md. 21228

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or compilcetions thet caused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in death)
e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or es e consequence of):

Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Lest
b.

Due to (or es e consequence of):
c.

Due to (or as a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

FATTY LIVER

23b. Did tobacco uee contribute to the cause of death?
1☐Yes 2☑No 3☐Probably 4☐Unknown

24e. Wes an autopsy performed?	24b. Were autopsy findings availeble prior to completion of ceuse of deeth?
1☑Yes 2☐No	1☑Yes 2☐No

25. Wes case referred to medicel exeminer?	26. Piece of Deeth (Check only one)	
1☒Yes 2☐No	Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Deeth	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Neturel 2☐Accident 3☐Sulcide 4☐Homicide 5☐Pending investigation 6☐Couid not be determined		M	1☐Yes 2☐No	

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only one)
1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) end manner es steted.
2☒ **Medical Examiner**: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, dete end piece, end due to the cause(s) and menner stated.

29b. Signeture end title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ Wayne Poellnitz	O.C.M.E	MAY 21,1998

30. Neme end address of person who completed ceuse of deeth (Item 23e) (Type, Print)
MARYANN A. KOLODNER 111 Penn Street, Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

State Registrar

31. Dete filed (Month, Dey, Year)	32. Registrar's Signature
MAY 26 1998	▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16183

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Shirley C Fritz
2. Date of Death: Month: May; Day: 20; Year: 98
3. Time of Death: 0320
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 212-40-5241
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 66 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/19/1931
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐ Yes 2☑ No
10e. Street and Number: 3034 Brookwood Rd.
10f. Zip Code: 21042
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembly Line
16b. Kind of Business/Industry: Distillery

17. Father's Name (First, Middle, Last): Jack London
18. Mother's Name (First, Middle, Maiden Surname): Frances Miller

19a. Informant's Name/Relationship (Type, Print): William Fritz Jr. /Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3034 Brookwood Rd. Ellicott City, Md. 21042

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lorraine Park Cemetery
Date: 5-22-98
20c. Location - City or Town, State: Baltimore Md.

21. Signature of Funeral Service Licensee: David J. Weber
22. Name and Address of Facility: David J. Weber Funeral Home 5311 Edmondson Ave. Baltimore, Md. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular Accident
Due to (or as a consequence of):
b. Diabetes Mellitus
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
c. Essential Hypertension
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D50377
29d. Date signed (Month, Day, Year): 5/20/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Perline, MD Howard County General Hospital

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

98 16184

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNA H. GRECKI

2. Date of Death (Month, Day, Year): May 18 1998

3. Time of Death: 12:46 pm

4a. Facility Name (If not institution, give street and number): STELLA MARIS

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-03-2809

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 07/01/1913

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: TOWSON

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 717 YORK ROAD

10f. Zip Code: 21204

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): LINE WORKER

16b. Kind of Business/Industry: McCORMICK & CO.

17. Father's Neme (First, Middle, Last): KAROL GRECKI

18. Mother's Name (First, Middle, Meiden Surneme): ANNA RACHUBA

19a. Informant's Neme/Relationship (Type, Print): RITA MICHNO BARRETT/SISTER

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 510 LIMERICK CIRCLE TIMONIUM, MD 21093

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): HOLY ROSARY CEMETERY

Date: 5/22/98

20c. Location - City or Town, State: DUNDALK, MD

21. Signature of Funeral Service Licensee: Phillip Stark

22. Name end Address of Facility: STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Final disease or condition resulting in death): e. Myocardial Infarction

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other eignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): ☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D 15504

29d. Dete signed (Month, Dey, Year): 5-14-98

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md. 21093

State Registrar

31. Date filed (Month, Dey, Year): MAY 26 1998

32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Heelth end Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit

NAME: GRECKI, ANNA

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16185

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMESE. GILL
2. Date of Death Month Day Year: MAY 21, 1998
3. Time of Death: 9:37AM.
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 217-38-6303
6. Sex: 1☐M 2☐F XX
7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-05-39
9. Birthplace (State or Foreign Country): NC

To Be Completed by Funeral Director

Usual Residence of Decedant

10a. State: Md.
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐Yes 2☐No XX
10e. Street and Number: 2731 E. Biddle Street
10f. Zip Code: 21213
10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐Yes 2☒No If Yas, Giva Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- It Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, atc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th Grade | College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: various trades
17. Father's Name (First, Middle, Last): Allie Gill
18. Mother's Name (First, Middle, Maiden Surname): Lucy Wilkerson
19a. Informant's Name/Relationship (Type, Print): Vivian Eggleston
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2731 E. Biddle Street Baltimore, Maryland 21213
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Cemetery
Date: 05-27-98
20c. Location - City or Town, State: Baltimore, Md.
21. Signature of Funeral Service Licensee: Francis M
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 e. North Avenue

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on aach lina.

Approximata Interval Between Onset and Death

Immediata Cause (Final disease or condition resulting in death): a. MALIGNANT HYPERTHERMIA — SUDDEN

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediata ceuse. Entar Underlying Cause (Disease or Injury that Initiated events rasulting in death) Last:
b.
Due to (or as a consequance of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceuse given in Part I.

DEMENTIA
CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was cese refarred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicida 5☐Pending investigation 6☐Could not be datarminad

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐Certifying Physician 2☐Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rivera
29c. License number: D0834
29d. Date signed (Month, Day, Year): 5/22/98

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): 5714 HARFORD RD, BALTIMORE MD 21214 Luis E. Rivera-Ramirez

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

ADH
98-2838-510
CLARENCE GREEN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16186

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Clarence L. Green
2. Dete of Death Month: MAY Dey: 19, Year: 1998
3. Time of Death: 23:40 PM
4e. Facility Neme *(If not Institution, give street and number)*: 623 EAST 33rd STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Deeth: n/a

Funeral Director

5. Social Security Number: 214-64-0803
6. Sex: 1 XX M 2 ☐ F
7. Age *(In yrs. last birthday)*: 44 Yrs. — If Under 1 Yeer: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Dec. 3, 1953
9. Birthplece *(Stete or Foreign Country)*: Md.

Usual Residence of Decedent

10a. Stete: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: XX 1 Yes 2 ☐ No
10e. Street and Number: 623 E. 33rd Street
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Merital Status: 1 XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XX No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XX No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* Black

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 10th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Handy Man
16b. Kind of Business/Industry: General Labor

17. Father's Neme *(First, Middle, Last)*: Clarence Green
18. Mother's Name *(First, Middle, Maiden Sumeme)*: Lucille Moison

19e. Informent's Neme/Reletionship *(Type, Print)*: Lucille House mother
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 623 E. 33rd Street Baltimore, Md. 21218

20e. Method of Disposition: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Arbutus Memorial Park — Dete: May 22
20c. Location - City or Town, Stete: Baltimore, Md.

21. Signeture of Funeral Service Licensee: ▶ Daphne E. Prince
22. Neme end Address of Feciliity: Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. — Approximate Interval Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in death)
a. Hypertensive Arteriosclerotic Cardiovascular Disease
Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in death) Lest
b. Due to (or es a consequence of):
c. Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XX Unknown

24e. Wes en eutopsy performed? INSPECTION 1 ☐ Yes 2 X No
24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 XX Yes 2 ☐ No
26. Place of Deeth *(Check only one)*: Hospitel: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other *(Specify)*

27. Manner of Deeth: 1 X Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the cause(s) and menner es steted. 2 XX **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end manner stated.
29b. Signeture end title of certifier: ▶ Stysh K Mackey, MD
29c. License number: OCME
29d. Dete signed *(Month, Dey, Yeer)*: MAY 20, 1998

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print): Stephen Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 26 1998
32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mentel Hygiene. **Important: if item 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other treumetic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit ecce.

98-2776-510
B.K.S
WILLIAM GRAHAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16187

Items: 23 part I,II,27,28a-f per MEO G-759 5/29/98 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM R. GRAHAM, JR.
2. Date of Death Month Day Year: MAY 16, 1998
3. Time of Death: 2008 PM
4e. Facility Name *(If not institution, give street and number)*: ST.AGNES HOSPITAL E.R.- CHEST PAIN
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 218-90-8320
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 25 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 12/17/1973
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10e. State: MD
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4029½ Boarman Avenue
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*
16b. Kind of Business/Industry

17. Father's Name *(First, Middle, Last)*: William R. Graham, Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Marlene Graham

19a. Informent's Neme/Relationship *(Type, Print)*: William Graham, Sr.
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4029½ Boarman Avenue, Balto.,MD 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Woodlawn Cemetery
Date:
20c. Location - City or Town, State: Baltimore,Maryland

21. Signature of Funeral Service Licensee: ▶ Leroy O. Dyett
22. Name and Address of Facility: LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE.,BALTO.,MD21207

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ACUTE COCAINE & NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ASTHMA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical exeminer? XX Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient XX 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☐ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation XX 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*: found 5/16/98
28b. Time of Injury: unknown M
28c. Injury at Work? 1☐ Yes XX No
28d. Describe how injury occurred: Unknown
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*: Found at home
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 4862 Clifton Ave. Baltimore, Md.

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) and manner as stated. XX **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier: ▶ Dennis J. Chute MD
29c. License number: O.C.M.E
29d. Dete signed *(Month, Day, Year)*: MAY 17, 1998

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, pege 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

REB

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16188

Certificate of Death

Reg. No.

JAMES OLIVER HARE, SR.
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James Oliver Hare, Jr.
2. Data of Death Month / Day / Year: MAY 21 1998
3. Time of Death: 3:45 PM
4a. Facility Name *(If not institution, give street and number)*: 25 South Highland Ave.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-26-3271
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 58 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: DEC 30, 1939
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 25 South Highland Ave.
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

To Be Completed by Funeral Director

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Driver
16b. Kind of Business/Industry: Trucking
17. Father's Name *(First, Middle, Last)*: James Oliver Hare, Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Louise Frances Bartels
19a. Informant's Name/Relationship *(Type, Print)*: Helga Mrozinski/friend
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 25 South Highland Ave. Baltimore, MD 21224
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc. — Data: 5/22/98
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Bladder Cancer — 7 month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Resident Staff Physician
29c. License number: D19714
29d. Date signed *(Month, Day, Year)*: 5/24/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL PORTER II JHPUML 4940 EASTERN AVE BALTIMORE, MD 21224

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998
32. Registrar's Signature: John Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16189

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Louis Holz

2. Date of Death Month: May Day: 21 Year: 1998

3. Time of Death: 8AM

4a. Facility Name *(If not institution, give street and number)*: SAINT AGNES NURSING

4b. City, Town, or Location of Death: Ellicott

4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 212-01-5843

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: 4-24-1901

9. Birthplace *(State or Foreign Country)*: Hungary

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9805 Cypressmede Drive

10f. Zip Code: 21042

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Barber

16b. Kind of Business/Industry: Barber Shop

17. Father's Name *(First, Middle, Last)*: Jacob Holz

18. Mother's Name *(First, Middle, Maiden Surname)*: Katherine Hindig

19a. Informant's Name/Relationship *(Type, Print)*: Arnold Holz / Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9805 Cypressmede Dr. Ellicott City, Md. 21042

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Loudon Park Cemetery | Date: 5-23-98

20c. Location - City or Town, State: Baltimore

21. Signature of Funeral Service Licensee: Paul T. Hagan

22. Name and Address of Facility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus Maryland 21227

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. UROSEPSIS — 20 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SENILITY
DEHYDRATION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: L Barahona

29c. License number: D21928

29d. Data signed *(Month, Day, Year)*: May 22nd 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LEONEL BARAHONA 3459 St Johns Lane Ellicott MD 21042

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 26 1998

32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16190

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Monroe L. Hackney
2. Date of Death Month: May Day: 20 Year: 1998
3. Time of Death: 6 30/Am
4a. Facility Name *(If not institution, give street and number)*: Mercy Medical Center
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: NA

Funeral Director

5. Social Security Number: 216-24-9235
6. Sex: XX 1 M 2 F
7. Age *(In yrs. last birthday)*: 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 10-2-28
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: Md
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: XX 1 Yes 2 No
10e. Street and Number: 716 West Hamburg Street
10f. Zip Code: 21230
10g. Citizen of What Country?: USA

11. Marital Status: XX Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XX No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 XX No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 10th Grade
College (1-4or 5+): NA
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Self-employed
16b. Kind of Business/Industry: Laborer

17. Father's Name *(First, Middle, Last)*: Monroe Hackney
18. Mother's Name *(First, Middle, Maiden Surname)*: Ellen Gunnells

19a. Informant's Name/Relationship *(Type, Print)*: Lavinia Young
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5642 Prince Georges Street Baltimore, Md. 21207

20a. Method of Disposition: XX 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King Mem. Pk. Cem. Date: 05-23-98
20c. Location - City or Town, State: Randallstown, Md

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Septic Shock — days

Due to (or as a consequence of):
b. Gram-negative bacteremia — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Pneumonia — days

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cirrhosis, gastric cancer, HIV infection

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 XX Unknown

24a. Was an autopsy performed? 1 Yes 2 XX No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 XX No

25. Was case referred to medical examiner? 1 Yes 2 XX No
26. Place of Death *(Check only one)*: Hospital: 1 XX Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other *(Specify)*
27. Manner of Death: 1 XX Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 XX **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D37790
29d. Date signed *(Month, Day, Year)*: May 20 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Neuns W Tadd 301 St Paul Place Baltimore

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998
32. Registrar's Signature: [signature] Sheila Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

- To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
- To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RB

2

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16191

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Janie Hayden
2. Data of Death Month Day Yaar: May 21, 1998
3. Time of Deeth: 7:07a.m.
4a. Facility Name *(If not institution, giva street and number)*: 3535 Denison Road
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 219-20-8978
6. Sax: 1☐ M 2☒ F
7. Age *(In yrs. last birthdey)*: 87 Yrs.
If Under 1 Yaar: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: Sept. 15, 1910
9. Birthplaca *(Stete or Foreign Country)*: Va.

Usuel Residenca of Decedent

10a. State: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street and Number: 3535 Denison Road
10f. Zip Code: 21215
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Detes:
13. Was Dacedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas ☒ No *Specify:*
14. Race - Americen Indian, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7th Grade; Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: Domestic
16b. Kind of Business/Indu stry: Private Family

17. Fether's Name *(First, Middle, Last)*: Bradford Nichols
18. Mother's Name *(First, Middla, Meiden Surneme)*: Martha Jane Jackson

19a. Informent's Name/Relationship *(Type, Print)*: Lenora K. Mitchell niece
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 3900 Primrose Avenue Baltimore, Md. 21215

20a. Mathod of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from Stata 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or othar piece)*: Shady Grove Cemetery
Date: May 28
20c. Location - City or Town, State: Goochland Co., Va.

21. Signature of Funaral Service Licensee: ▶ Herbert E. Nutter
22. Name end Addrass of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that causad tha death. Do not antar the mode of dying, such as cerdiec or respiretory arrest, shock, or heert feilure. List only one ceuse on each line. Approximate Interval Between Onsat and Death

Immediate Cause (Finel disease or condition resulting in deeth): e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or es e consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last:
b. HYPERTENSION
Dua to (or as a consequence of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☑ No

25. Was cese refarred to medical examinar? 1☐ Yes 2☑ No
26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, streat, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Steta)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the ceuse(s) and menner stated.

29b. Signetura and title of certifier: ▶ Ose Wusu MD
29c. License number: D24089
29d. Date signad *(Month, Day, Year)*: 05/22/1998

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): A. OSEI-WUSU MD 5710 WABASH AVE BALTIMORE MD 2215

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be reported within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Medical Certification: To Be Completed by Physician/Medical Examiner

4

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16192

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Janice Leslie Hamm

2. Date of Death: Month MAY Day 20th Year 1998

3. Time of Death: 9:10 pm

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-60-0419

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 45 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 12, 1952

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3607 Ash Street

10f. Zip Code: 21211

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bank Manager

16b. Kind of Business/Industry: Augusta Bank

17. Father's Name (First, Middle, Last): James Grady McDonald, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Janice Jeanette McDonald

19a. Informant's Name/Relationship (Type, Print): Barry Hamm, Sr. Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3607 Ash Street Baltimore, MD 21211

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Crest Lawn Memorial | Date: 5/22/98

20c. Location - City or Town, State: Marriottsville, MD

21. Signature of Funeral Service Licensee: Barry H Carpenter

22. Name and Address of Facility: Burgee-Henss Funeral Home, P.A. 3631 Falls Road Baltimore, MD 21211

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Respiratory Failure — minute

Due to (or as a consequence of):
b. metastatic lung cancer — 2 1/2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier: MD

29c. License number: 044944

29d. Date signed (Month, Day, Year): MAY 20th 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stan Walton MD Union Memorial Hospital Baltimore MD 21218

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Janice Hamm

10

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

RKD

98-2780-033

DONALD HAYDEN

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16193

Items:23 part I,II,27,28a-f per MEO G-760 6/1/98

Certificate of Death

reg

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Donald Hayden	MAY 16,1998	8:52P.M.

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LAUREL REGIONAL HOSPITAL	LAUREL	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-96-1494	1☒ M 2☐ F	74 Yrs.			May 1, 1924	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Howard	Columbia	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5449 Lockpenny Place	21045	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
N/A		None	None

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Unknown	Unknown

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
David Wamsley Guardian	9180 Rumsy Road Columbia, MD 21045

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	eMerge Inc. Meadowridge Memorial	5/22/98	Dorsey, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Tracy H. Carpenter	Burgee-Henss Funeral Home, P.A. 3631 Falls Road Baltimore, MD 21211

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. HEAD INJURIES	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

MENTAL RETARDATION

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural ☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	5/16/98	8:00 P M	1☐ Yes 2☒ No	Subject Fell

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Yard	14510 Bowie Rd. Laurel, Md.

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Dennis J. Chute MD	O.C.M.E.	MAY 17,1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 26 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 16194

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LORETTA ANNE HARRODY
2. Date of Death: Month MAY Day 16 Year 1998
3. Time of Death: 5:30 PM
4a. Facility Name (If not institution, give street and number): 2801 OSWEGO AVE.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-20-0035
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 70 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUN. 12, 1927
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 2801 OSWEGO AVE
10f. Zip Code: 21215
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 TH; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PRESSOR
16b. Kind of Business/Industry: CLEANER

17. Father's Name (First, Middle, Last): Roy A. Wade Sr.
18. Mother's Name (First, Middle, Maiden Surname): Mary Thompson

19a. Informant's Name/Relationship (Type, Print): Joseph Harrody
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2801 Oswego Ave Balto, MD. 21215

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☑ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park
Date: 5/21/98
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gary E. March Funeral Home P.A. 270 Fredrick Pass Balto, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Seizure disorder

Due to (or as a consequence of):
b. Coronary artery disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. cerebral V/S senior accident

Due to (or as a consequence of):
d. Diabetes mellitus

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Bronchitis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D30115
29d. Date signed (Month, Day, Year): 5/21/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): T. Ohio Kpelai MD 2600 Liberty Hgts Ave. Balto MD 21215

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

4

6

DHMH 16 Rev 6/95

98-2789-510
CMK
CLARENCE HARRISON

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16195

Items: 23 part I,27,28a-f per MEO G-759 5/28/98 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLARENCE HARRISON
2. Date of Death Month Day Year: MAY 17, 1998
3. Time of Death: 1828PM
4a. Facility Name (If not institution, give street and number): ST. AGNES HOSPITAL E.R.
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 230-66-9739
6. Sex: 1☑M 2☐F
7. Age (In yrs, last birthday): 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr 12, 1949
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑Yes 2☐No
10e. Street and Number: 2647 HURON ST.
10f. Zip Code: 21230
10g. Citizen of What Country? U.S.A

11. Marital Status: 1☑Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☑Yes 2☐No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10TH | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MEAT CUTTER
16b. Kind of Business/Industry: POULTRY

17. Father's Name (First, Middle, Last): JOE SAM HARRISON
18. Mother's Name (First, Middle, Maiden Surname): CORA BELLE RIDLEY

19a. Informant's Name/Relationship (Type, Print): DOLORES HARRISON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2647 HURON ST, BALT. MD. 21230

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST | Date: 5/23/98
20c. Location - City or Town, State: OWINGS MILLS MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: GARY L. MARCH FUNERAL HOME P.A. 270 FREDHILTON PKWY BALT. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE ALCOHOL INTOXICATION
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☑Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☑Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation ☒Could not be determined
28a. Date of Injury (Month, Day Year): found 5/17/98
28b. Time of Injury: found 5:00 P M
28c. Injury at Work? 1☐Yes ☒No
28d. Describe how injury occurred: Unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Found at residence
28f. Location (Street and Number or Rural Route Number, City or Town, State): 2647 Huron St. Baltimore, Md.

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): MAY 18, 1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R. Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 96 16196

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Charlotte Shannon Henry
2. Date of Death — Month: May; Day: 24; Year: 1998
3. Time of Death: 4:00 Am

4a. Facility Name *(If not institution, give street and number)*: 2943 Knoll Circle
4b. City, Town, or Location of Death: Ellicott City
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 195-18-2185
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jul 25 1915
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2943 Knoll Circle
10f. Zip Code: 21043
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12); College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher high school
16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Benjamin Franklin Shannon
18. Mother's Name *(First, Middle, Maiden Surname)*: Amelia Pauline Wachsmuth

19a. Informant's Name/Relationship *(Type, Print)*: John F. Henry Jr. (Husband)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2943 Knoll Circle Ellicott City, MD 21043

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Baltimore Washington Crematory
Date: 5/28 1998
20c. Location - City or Town, State: Laruel, MD

21. Signature of Funeral Service Licensee: Frank L Lemmer
22. Name and Address of Facility: Witzke Funeral Homes, Inc 1630 Edmondson Ave Catonsville, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. End Stage Parkinsons Disease — 1 Month
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☒ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward J. Kaul
29c. License number: D34951
29d. Date signed *(Month, Day, Year)*: 5-24-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edward J Kaul 405 Frederick Rd Ste 100 Catonsville MD 21228

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998
32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 16197

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mildred D. Huller

2. Date of Death — Month: May; Day: 21; Year: 1998

3. Time of Death: 7:25 pm

4a. Facility Name *(If not institution, give street and number)*: Lorien Nursing Center - Riverside

4b. City, Town, or Location of Death: Belcamp

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 218-07-6483

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Yaar — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: October 7, 1919

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll Co.

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2717 Coon Club Road

10f. Zip Code: 21157

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementery/Secondery (0-12): 7

College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Andrew Sachs, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Eva M. Rixse

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Paul T. Huller, Jr. / Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 200-L Burkwood Court Bel Air, MD 21015

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery

Date: 5/26/1998

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Michael E. Canapp

Michael E Canapp

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one cause on aach line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery disease — 7 years

Due to (or as a consequence of):

Sequentially list conditions, If eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditfone** contributing to death but not resulting in the underlying causa given in Part I.

alzheimer's disease + dementia

23b. Dfd tobacco use contribute to the causa of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Phyeician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medfcal Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. Licansa number: D28334

29d. Date signed *(Month, Day, Year)*: May 22, 1998

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): LINDA Hancock 101 E. Wells Road Bel Air MD 21015

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 26 1998

32. Registrar's Signature

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

04. Name: Mildred Huller

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16198

Certificate of Death

Item#7 per FH G759 5/26/98 EW

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charlotte Audrey Jamison

2. Date of Death Month: MAY Day: 19 Year: 1998

3. Time of Death: 10:55pm

4a. Facility Name (If not institution, give street and number): Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 219-22-1267

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): ~~71~~ 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB 3, 1926

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 300 Sunflower Drive

10f. Zip Code: 21014

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Carl Hopple

18. Mother's Name (First, Middle, Maiden Surname): UNK.

19a. Informant's Name/Relationship (Type, Print): Norman G. Jamison/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2106 White House Rd. Bel Air, MD 21015

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.

Date: 5/22/98

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. HUNTINGTON'S DISEASE	6 YEARS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Andrew Nowakowski MD

29c. License number: D08096

29d. Date signed (Month, Day, Year): MAY 20, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ANDREW NOWAKOWSKI MD 125 N. MAIN ST BEL AIR MD 21014

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998

32. Registrar's Signature: Gloria Dorsey-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Charlotte Audrey Jamison

441

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16199

Item#23a part 1 A,B,C, PER Phy G759 5/26/98 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARIE JOHNSON

2. Date of Death — Month: MAY; Day: 15th; Year: 98

3. Time of Death: 1:55 pm

4a. Facility Name *(If not institution, give street and number)*: Franklin Woods Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 232 28 9569

6. Sex: 1☐ M 2☑ F

7. Age *(In yrs. last birthday)*: 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 24 1918

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1☐ Yes 2☑ No

10e. Street and Number: 9751 Magledt Rd.

10f. Zip Code: 21234

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 11 — College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Salesperson

18b. Kind of Business/Industry: Retail

17. Father's Name *(First, Middle, Last)*: James Vanscoy

18. Mother's Name *(First, Middle, Maiden Surname)*: Dolly Taylor

19a. Informant's Name/Relationship *(Type, Print)*: Pat Chlebda

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9751 Magledt Rd. Parkville MD 21234

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Parkwood Cemetery

Date: MAY 19 1998

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: EVANS Funeral Chapel 8800 Harford Rd. Baltimore MD. 21234

23a

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ~~Renal failure~~ Brights Disease — 20 yrs

Due to (or as a consequence of):

b. Renal Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Anemia

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Anemia.

Malnutrition.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)* — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)* — 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rajapati M.D

29c. License number: D50757

29d. Date signed *(Month, Day, Year)*: May 15th 98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANURADHA N RAJAPATI 9105 Franklin Sq Drive #312 Baltimore

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998

32. Registrar Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16200

Keller, William

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last): William Christopher Keller			2. Date of Death (Month, Day, Year): May 22 1998	3. Time of Death: 4 12 pm
4a. Facility Name (If not institution, give street and number): Gilchrist Center	4b. City, Town, or Location of Death: Towson	4c. County of Death: Baltimore		
5. Social Security Number: 185-48-0255	6. Sex: 1☒M 2☐F	7. Age (In yrs. last birthday): 40 Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN 10, 1958	9. Birthplace (State or Foreign Country): Pennsylvania			

Usual Residance of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1101 St. Paul Street Unit 1012	21202	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
	4	Architect	Architecture

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William B. Keller	Louise A. Clemente

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William B. Keller/father	3411 103rd Drive NW Gainesville, FL 32606

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cramation 3☐Ramoval from State 4☐Donation 5☐Other (Specify)	Metro Crematory, Inc.	5/23/98	Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseasa, or complications that ceusad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onsat and Death
Immediate Cause (Final disaase or condition resulting in deeth)	e. Aspergillus infection of Brain / Sinuses	9 months
	Due to (or es e consequence of): Acquired Immunodeficiency Syndrome	
Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury thet initiated events rasulting in deeth) Last	b. Due to (or es e consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. Othar significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causa of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of causa of death?
1☐Yes 2☒No	1☐Yes 2☐No N/A

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpetient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) HOSPICE

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. injury at Work?	28d. Describe how injury occurred
1☒Netural 2☐Accident 3☐Sulcida 4☐Homlcide 5☐Pending Investigation 6☐Could not be determined	N/A	N/A M	N/A 1☐Yes 2☐No	N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
N/A	N/A

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or Investigetion, in my opinion, death occurred et the time, dete and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licansa number	29d. Date signed (Month, Day, Year)
Janet Horn MD	D25169	5/22/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Janet Horn, MD 10755 Falls Rd Suite 310 Lutherville, Md. 2093

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

3

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 26 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item#29c per Phy G759 5/26/98 EW

Certificate of Death

98 16201

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edith R. Kahn

2. Date of Death: Month MAY Day 20 Year 1998

3. Time of Death: 1605

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 214-40-9700

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 56 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV. 7, 1941

9. Birthplace (State or Foreign Country): WASH., DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: OWINGS MILLS

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6 BETH CT.

10f. Zip Code: 21117

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): EXECUTIVE SECRETARY

16b. Kind of Business/Industry: CHEMICAL MANUFACTURING

17. Father's Name (First, Middle, Last): DAVID SAKS

18. Mother's Name (First, Middle, Maiden Surname): REBA SIGEL

19a. Informant's Name/Relationship (Type, Print): DONALD KAHN (HUS.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6 BETH CT. OWINGS MILLS, MD 21117

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): HEBREW YOUNG MEN

Date: 5/22/98

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Scott M. Cuttler

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic Renal Failure

Due to (or as a consequence of):

c. Acute myocardial infarction

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: P 11245

29d. Date signed (Month, Day, Year): MAY 20 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Troy Ockerman, MD 2401 W. Belvedere Avenue Baltimore, MD 21215

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998

32. Registrar Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

98 16202

Item 7, 19a per FH Film G759 5-26-98 rja

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GOLDIE KAPLAN			2. DATE OF DEATH (Month, Day, Year): MAY 21, 1998	3. TIME OF DEATH: 8:30 AM
4. SOCIAL SECURITY NUMBER: 230-07-8533	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): JAN. ~~14~~ 15 1917	8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): JEWISH CONVALESCENT CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 6948 BROOKMILL RD.		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PROPRIETOR	16b. KIND OF BUSINESS/INDUSTRY: JEWELRY STORE	
17. FATHER'S NAME (First, Middle, Last): MICHAEL KLAFF		18. MOTHER'S NAME (First, Middle, Maiden Surname): SARAH FAMALONT	
19a. INFORMANT'S NAME (Type/Print): JULIAN ~~KAPLAN~~ Klaff (BRO.)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 711 LEAFYDALE TERRACE BALTO., MD 21208	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BETH JACOB ANSHE VESHEAR	20c. LOCATION — City or Town, State: 5/22/98 ROSEDALE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellerslie Levinson Jeffers		22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MYOCARDIAL INFARCTION	IMMEDIATE
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATHEROSCLEROTIC HEART DISEASE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D15740	29d. DATE SIGNED (Month, Day, Year): ▶ MAY 21, 1998

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] SUNSHINE MD 6210 Pk. Heights Ave, Balto MD 21215

31. DATE FILED (Month, Day, Year): MAY 26 1998	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 16203
Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: CATHERINE M. KERBY
2. Dete of Death Month Dey Yeer: May 20, 1998
3. Time of Death: 6:50 am
4a. Facility Neme *(If not institution, give street end number)*: Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-14-8392
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthdey)*: 79 Yrs. | If Under 1 Yeer: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: March 20,1919
9. Birthplace *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10e. Stete: Md.
10b. County: Baltimore
10c. City, Town or Location: Middle River
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 603 Landitian Road
10f. Zip Code: 21220
10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12th; College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk
16b. Kind of Business/Industry: Grocery STore

17. Fether's Neme *(First, Middle, Last)*: Frederick Siegman
18. Mother's Name *(First, Middle, Maiden Surneme)*: Katherine

19e. Informent's Neme/Reletionship *(Type, Print)*: FrederickO. Kerby/husband
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 603 Landitian Road Baltimore Md. 21220

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Plece of Disposition *(Neme of cemetery, cremetory or other plece)*: Holly Hill Cemetery
Date: 5/23/98
20c. Locetion - City or Town, Stete: Baltimore Md.

21. Signeture of Funeral Service Licensee: R. Terry Connelly
22. Neme end Address of Fecility: Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immedeite Cause (Final disease or condition resulting in deeth)
e. Squamous Cell Cancer of Cheek and Neck — 2½ Years

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest
b.
Due to (or es e consequence of):
c.
Due to (or es a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings avellable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Locetion *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete end placa, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: S. Raguraj
29c. License number: RD 188813
29d. Dete signed *(Month, Dey, Yeer)*: 05/20/98

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): Sinnarajan Raguraj M.D. 9000 Franklin Square Drive Baltimore, MD 21237

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: MAY 26 1998
32. Registrer's Signature: Jutta Davidson-Randall

DHMH 16 Rev 6/95

Catherine Kerby
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16204

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALPHONSE EDWARD LITZ, SR
2. Date of Death (Month, Day, Year): MAY 18, 1998
3. Time of Death: 215PM
4a. Facility Name (If not institution, give street and number): CARROLL COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Death: WESTMINSTER
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 105-05-3653
6. Sex: 1☒ M 2☐ F (XX)
7. Age (In yrs. last birthday): 99 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09/30/1898
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD
10b. County: CARROLL
10c. City, Town or Location: ELDERSBURG
10d. Inside City Limits: 1☐ Yes 2☒ No (X)
10e. Street and Number: 1088 MONTCLAIRE DRIVE
10f. Zip Code: 21784
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed (X) 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No (X) If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No (XX) Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERK
16b. Kind of Business/Industry: CRUCIBLE STEEL CO.

17. Father's Name (First, Middle, Last): FRANCIS LITZ
18. Mother's Name (First, Middle, Maiden Surname): JOSEPHINE (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): ALPHONSE E. LITZ, JR./SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 303 CENTER STREET SYRACUSE, NY 13209

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. MARY'S CEMETERY | Date: 5/22/98
20c. Location - City or Town, State: DeWITT, NY

21. Signature of Funeral Service Licensee: Robert C. Ferris
22. Name and Address of Facility: STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. PNEUMONIA — 3DAYS

Due to (or as a consequence of):
b. CHRONIC OBSTRUCTIVE PULMONARY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. DISEASE — 8YEARS

Due to (or as a consequence of):
d. CORONARY ARTERY DISEASE — 8YEARS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dan H. Schneiderfer MD
29c. License number: D28221
29d. Date signed (Month, Day, Year): MAY 18, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAN H. SCHNEIDERFER, MD CARROLL COUNTY GENERAL HOSPITAL

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998
32. Registrar's Signature: Trisha Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

HX1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 16205

Item#18 per FH G759 5/26/98 EW

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Helen		LAPORTE	MAY 22, 1998	9:55 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FRANKLIN Square Hospital Center	Rosedale	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220144554	1☐ M 2☒ F	79 Yrs.			~~MAY 22, 1998~~ 10-13-18	W. VIRGINIA

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	ROSEDALE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5920 SHADY SPRING	21237	USA

11. Meritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - Americen Indien, Bleck, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elamantary/Secondary (0-12)	College (1-4or 5+)		
12	0	TEACHER	Balto City Schools

17. Fether's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumeme)
LINWOOD J. STOVER	PEARL FRIES

19a. Informent's Neme/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)
RONALD LaPORTE/ SON	5920 SHADY SPRING ROSEDALE, MARYLAND 21237

20e. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)	METRO CREMATORY	5/26/98	BALTIMORE, MD

21. Signeture of Funerel Service Licensee ▶

22. Neme end Address of Fecility
CVACH/ROSEDALE FUNERAL HOME
1211 CHESACO AVENUE BALTO, MD 21237

Physician /Medical Examiner

23e. Pert I. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Finel diseese or condition resulting in daath) a.	PNEUMONIA	2 DAYS
Due to (or es a consequence of):		
b.	Aspiration	2 DAYS
Sequentiatly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest Due to (or es e consequence of): c.	Dementia	10 YEARS
Due to (or es e consequence of): d.		

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

Atrial Fibrilation

Anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes an eutopsy performed?	24b. Were eutopsy findings availeble prior to completion of ceuse of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was cese referred to medicel exeminer?	26. Place of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth	28e. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, ferm, street, fectory, office buitding, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and piece, end due to the ceuse(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, death occurred et the time, date end piece, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ , MD	D37612	MAY 22, 1998

30. Neme end eddress of person who comptated ceusa of deeth (Item 23e) (Type, Print)
Mohamad Alabrash, M.D. 9000 Franklin Square Dr. Balto. MD. 21237

State Registrar

31. Dete filed (Month, Dey, Yeer)	32. Registrar's Signeture
MAY 26 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16206

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
JAMES	HENRY	LEWIS	May	20	1998	845 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
UNION MEMORIAL HOSPITAL	BALTIMORE CITY	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
248-58-2536	1☒M 2☐F	58 Yrs.					MAY 13 1940	SOUTH CAROLINA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	N/A	BALTIMORE CITY	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1800 SHERWOOD AVENUE	21239	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11th grade		TRUCK DRIVER	JOSEPH J. HOCK CO

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JAMES SAMUEL	ESTELLE MILLER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Hattie Lyons/Friend	1800 Sherwood Avenue, Baltimore, Maryland 21239

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	KING MEMORIAL PARK	5-23	BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Harry P. Carr	WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Multi system organ failure	4 days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	AT2438948	May 20, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nomi Shaood MD Union Memorial Hospital Baltimore MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 26 1998	Julie Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

James Henry Lewis

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16207

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SALVATORE COSIMO LIBERTO
2. Date of Death Month / Day / Year: May 18 1998
3. Time of Death: 10:20am
4a. Facility Name *(If not institution, give street and number)*: 4 South Lake Way
4b. City, Town, or Location of Death: Reisterstown
4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 178-16-3122
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct 20, 1922
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore Co.
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4 South Lake Way
10f. Zip Code: 21136
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk
16b. Kind of Business/Industry: retail grocery

17. Father's Name *(First, Middle, Last)*: Cosimo Liberto
18. Mother's Name *(First, Middle, Maiden Surname)*: Rosine Aquila

19a. Informant's Name/Relationship *(Type, Print)*: Steve Liberto - son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4 South Lake Way, Reisterstown, MD 21136

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lake View Memorial — Date: May 22, 1998
20c. Location - City or Town, State: Sykesville, MD

21. Signature of Funeral Service Licensee: Jeffrey Bell
22. Name and Address of Facility: Eline Funeral Home, 11824 Reisterstown Rd. Reisterstown, MD 21136

Physician /Medical Examiner

23e. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Brain Tumor	9 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Nicholas Koutrelakos MD
29c. License number: D38509
29d. Date signed *(Month, Day, Year)*: May 20 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Nicholas Koutrelakos 11065 Little Patuxent Pkwy Columbia MD 21044

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10x1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16208

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Major Lee

2. Date of Death Month Day Year: May 15, 1998

3. Time of Death: 4:00 PM

4a. Facility Name (If not institution, give street and number): 3134 Lugine Ave.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 242-52-1979

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 14, 1925

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: N.C.

10b. County: Halifax

10c. City, Town or Location: Littleton

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 501 Solomon Drive

10f. Zip Code: 27850

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: N.C. Public School

17. Father's Name (First, Middle, Last): Charlie Lee

18. Mother's Name (First, Middle, Maiden Surname): Estelle Solomon

19a. Informant's Name/Relationship (Type, Print): Mrs. Doris Faulkner (niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3134 Lugine Ave. Balto. Md. 21207

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Pleasant Hill Miss. Bapt. Ch. Cem. Date: 5/23/98

20c. Location - City or Town, State: North Carolina

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home, 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PROBABLE ACUTE MYOCARDIAL INFARCTION	< 5 min
Due to (or as a consequence of):	b. CORONARY ARTERY DISEASE	> 10 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CEREBROVASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Attending

29c. License number: D40320

29d. Date signed (Month, Day, Year): MAY 18, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): P.R. DESAI, MD, 5310 OLD COURT RD, #307, RANDALLSTOWN, MD 21133

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16209

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Oscar George Laudenslayer

2. Date of Death (Month, Day, Year): MAY 19, 1998

3. Time of Death: 3:50 PM

4a. Facility Name (If not institution, give street and number): VAMHCS FORT HOWARD DIVISION

4b. City, Town, or Location of Death: FORT HOWARD

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 121-10-1364

6. Sex: 1☐M 2☐F — X

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 24, 1913

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 1703 Norfolk Road

10f. Zip Code: 21061

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Trust Officer

16b. Kind of Business/Industry: Banking

17. Father's Name (First, Middle, Last): Frank George Laudenslayer

18. Mother's Name (First, Middle, Maiden Surname): Virginia Harriet Cooper

19a. Informant's Name/Relationship (Type, Print): Lillian Laudenslayer/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1703 Norfolk Road, Glen Burnie, Maryland 21061

20a. Method of Disposition: 1☐Burial 2☐Cremation 3☐Removal from State 4☒Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Joseph B. Van Sant

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CANCER, PROSTATE WITH METASTASIS — 4 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MELANOMA, HYPERTENSION, CHRONIC OBSTRUCTIVE LUNG DISEASE, STROKE

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year):

28b. Time of Injury: M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):

28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Aurora C. Tan, M.D.

29c. License number: D14958

29d. Date signed (Month, Day, Year): 05/19/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AURORA C. TAN, M.D.--9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

LAUDENSLAYER, OSCAR G.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16210

Item: 16b, per F.H. G-759 5/26/98 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NORMAN LIBOWITZ
2. Date of Death (Month, Day, Year): MAY 22, 1998
3. Time of Death: 6 05 AM

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-22-4585
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): MAY 10, 1927
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No XX
10e. Street and Number: 3504 ARBORWOOD COURT
10f. Zip Code: 21208
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 [ ] Yes 2 [X] No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BROKER
16b. Kind of Business/Industry: MORTAGE ~~MANAGEMENT~~

17. Father's Nama (First, Middle, Last): ALBERT LIBOWITZ
18. Mother's Name (First, Middle, Malden Surname): IDA S. SHERRY

19a. Informant's Name/Relationship (Type, Print): MRS. MAXINE LIBOWITZ (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3504 ARBORWOOD COURT BALTIMORE, MD 21208

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cramatory or othar placa): BALTIMORE HEBREW
Data: 5-24-1998
20c. Location - City or Town, State: BALTIMORE, MD

21. Signatura of Funeral Service Licensee: Quentin H. Sherman
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD BALTO., MD 21208

Physician /Medical Examiner

23a. Part I. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in daath): a. SUSTAINED VENTRICULAR FIBRILLATION — SEVERAL MINUTES

Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Cause (Disaase or injury that initiated avents rasulting in daath) Last:
b. Due to (or as a consaquence of):
c. Due to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to daath but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE STATUS POST CORONARY ARTERY BYPASS AND GRAFT
OLD MYOCARDIAL INFARCTION, DEPRESSION

23b. Did tobacco use contribute to the causa of death? 1 [ ] Yas 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Ware autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was casa rafarrad to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Homa 5 [ ] Residence 8 [ ] Othar (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurrad at the time, date and placa, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifier: MD.
29c. License number: D19502
29d. Data signed (Month, Day, Year): MAY 22, 1998

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print): ORLANDO B. CONANAN MD — NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD. 21133

State Registrar

31. Date filad (Month, Day, Year): MAY 26 1998
32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rav 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

98 16211

State of Maryland / Department of Health and Mental Hygiene

Item 20a per FH Film G759 5-26-98 rja

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: TED H. LEVIN

2. Date of Death: Month: May; Day: 19; Year: 1998

3. Time of Death: 12:20 AM

4a. Facility Name *(If not institution, give street and number)*: SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE City

Funeral Director

5. Social Security Number: 214-16-8851

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months; Days

If Under 24 Hrs.: Hours; Min.

8. Date of Birth *(Month, Day, Year)*: MAY 18, 1916

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 720 HOWARD RD.

10f. Zip Code: 21208

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MANAGER

16b. Kind of Business/Industry: AUTOMOBILES

17. Father's Name *(First, Middle, Last)*: WILLIAM LEVIN

18. Mother's Name *(First, Middle, Maiden Surname)*: ANNA FINK

19a. Informant's Name/Relationship *(Type, Print)*: SHIRLEY LEVIN (WIFE)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 720 HOWARD RD. BALTO., MD 21208

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other *(Specify)* Mausoleum

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: DRUID RIDGE

Date: 5/22/98

20c. Location - City or Town, State: PIKESVILLE, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS — 4 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Encephalitis.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Date of Injury *(Month, Day Year)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: AS240232 1DM9439

29d. Date signed *(Month, Day, Year)*: May 19, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DWIGHT C. MILLER, MD SINAI HOSPITAL.

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998

32. Registrar's Signature: [signature] Julie Davidson Randall

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12+1

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16212

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Anna Virginia Mills	May 25, 1998	7:40 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Rock Glen Nursing & Rehabilitation Ctr.	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-01-7276	1☐ M 2☒ F	81 Yrs.			JULY 17, 1916	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore	X 1☐ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5168 Stafford Road	21229	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yaar or Dates: X	1☐ Yes 2☒ No Specify: X	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Sales Clerk	Drug Store

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Sumeme)
John Patrick Lee	Josephine M. Nichol

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
Creston J. Mills, Sr./Husband	5168 Stafford Rd. Baltimore, MD 21229

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Loudon Park Cemetery	5/28/98	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Edward A. Gregorchik	MacNabb Funeral Home, P.A. 301 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

		Approximate Intervel Between Onset end Deeth
Immediate Ceuse (Final diseese or condition resulting in death)	e. Metastatic cancer	3 mo
	Due to (or es a consequence of):	
Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Last	b. Carcinoma of colon	3 mo
	Due to (or es a consequence of):	
	c.	
	Dua to (or as e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cauee of death? 1☐ Yee 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed?	24b. Were eutopsy findings aveilable prior to completion of cause of death?
1☐ Yas 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Deeth (Check only one)	
1☐ Yas 2☑ No	Hospital: 1☐ Inpatiant 2☐ ER/Outpetient 3☐ DOA	Other: 4☑ Nursing Homa 5☐ Rasidence 6☐ Other (Specify)

27. Menner of Deeth	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Invastigation 6☐ Could not be determined		M	1☐ Yas 2☐ No	
	28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Sakaran	D21649	May 26, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. BASKARAN 3455 Wilkens Ave. Baltimore MD 21229

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signeture
MAY 26 1998	▶ Lydia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Haalth end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit.

DHMH 16 Rev 6/95

RKD

98-2832-510

PORTER
MORRISON

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16213

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PORTER MORRISON JR.

2. Date of Death: Month MAY Day 19, Year 1998

3. Time of Death: 11:15A.M.

4a. Facility Name (If not institution, give street and number): 2 N.MONROE STREET

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-38-4300

6. Sex: 1☑M 2☐F

7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC.07,1938

9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1☑Yes 2☐No

10e. Street and Number: 2 NORTH MONROE STREET

10f. Zip Code: 21229

10g. Citizen of What Country? USA.

11. Marital Status: 1☑Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☑Yes 2☐No If Yes, Give Year or Dates: 10-30-61 8-21-64

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): MASTERS DEGREE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SCHOOL TEACHER

16b. Kind of Business/Industry: BALTIMORE CITY

17. Father's Name (First, Middle, Last): PORTER MORRISON SR,

18. Mother's Name (First, Middle, Maiden Surname): OGLETHA INGRAM

19a. Informant's Name/Relationship (Type, Print): JULIUS FINCH (COUSIN)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 NORTH MONROE STREET, BALTIMORE, MD. 21229

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): WAYMAN CHAPEL CHURCH CEME. Date: 5-29-98

20c. Location - City or Town, State: HAMLET, N.C.

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME, PA. 2140 N. FULTON AVE. BALTIMORE, MD. 21217

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive atherosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? INSPECTION 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Stephen S. Nadeau, MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): MAY 20, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998

32. Registrar Signature: Lydia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16214

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
George Markovich	MAY 22 1998	8:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Gilchrist Center	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
720-14-3484	1☒M 2☐F	78 Yrs.			OCT 16, 1919	Illinois

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Howard	Ellicott City	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10053 Carillon Drive	21042	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No 1941-45	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12		Carpenter	Construction

17. Father'a Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Martin Markovich	Helen Mikulich

19a. Informant's Name/Relationship (Type, Print)	19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
Georgina Harding/daughter	10053 Carillon Drive Ellicott City, MD 21042

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, crematory or other placa)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metro Crematory, Inc.	5/23/98	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Edward A. Gregorchik	Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. metastatic colon cancer	3 months
	Due to (or as a consequenca of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequenca of):	
	d.	

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Wes an autopsy performed?	24b. Were autopsy findinga available prior to complation of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residenca 6☒Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end pleca, and due to the cause(s) and manner es stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
▶ W. Anthony Riley, MD	D25205	MAY 22, 1998

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print)
W. A. Riley GBMC 6701 N. Charles St, Balto. Md 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registar's Signature
MAY 26 1998	Judy Davidson-Randall

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician**: The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Markovich Bridge 5/20/98 8am

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16215

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Lest): Marie L. Maas
2. Deta of Daath: Month May Day 25, Yaer 1998
3. Time of Death: 1:55PM
4a. Facility Neme (If not institution, give street end number): Lorien Frankford Nursing Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 215-34-7555
6. Sax: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 101 Yrs. — If Under 1 Yeer: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Dey, Yeer): 7-19-1896
9. Birthpiece (State or Foreign Country): MD

Usuel Residence of Decedent

10e. Stete: MD
10b. County: Baltimore
10c. City, Town or Location: Rosedale
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 8358 Old Philadelphia Rd.
10f. Zip Code: 21237
10g. Citizen of Whet Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armad Forcas? 1☐ Yes 2☒ No If Yes, Give Yeer or Datas:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Reca - Americen indien, Bleck, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): unk. College (1-4or 5+): 0
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Fether's Neme (First, Middle, Lest): Charles Kline
18. Mother's Name (First, Middle, Maiden Surneme): Catherine Dignan
19e. Informent's Neme/Relationship (Type, Print): Dorothy Fajkowski/daughter
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 8358 Old Philadelphia Rd. Rosedale, MD 21237
20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removei from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other pieca): Gardens of Faith
Dete: 5-29-98
20c. Location - City or Town, Stete: Baltimore, MD
21. Signature of Funerel Service Licensee: [signature]
22. Neme end Address of Feciliity: Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 21237

Physician /Medical Examiner

23e. Pert I. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete intervei Between Onset end Death

tmmediete Ceuse (Finei diseese or condition resulting in death): e. Atherosclerotic CardioVascular Disease — YEARS

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest:
b.
Due to (or es e consequence of):
c.
Due to (or as e consequence of):
d.

Pert ti. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert i.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings aveileble prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospitel: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Deta of injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et tha time, date and piace, end due to the cause(s) and manner stated.

29b. Signeture and title of certifier: Fredric S. Sorkis M.D.
29c. License number: D22645
29d. Date signed (Month, Dey, Yeer): 5/26/98

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): FREDRIC S. SORKIS M.D. 7151 HOLABIRD AVE. BALTO. MD. 21222

State Registrar

31. Dete filed (Month, Day, Yeer): MAY 26 1998
32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 98 16216

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: LOUISE E. MARTIN
2. Date of Death Month: MAY Day: 18 Yeer: 1998
3. Time of Deeth: 928AM
4e. Fecility Neme *(If not institution, give street and number)*: 1226 CIRCLE DRIVE
4b. City, Town, or Location of Death: ARBUTUS, MARYLAND
4c. County of Deeth: BALTIMORE

Funeral Director

5. Sociel Security Number: 218-07-6105
6. Sex: 1☐ M 2☒ F XX
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: 09-30-1915
9. Birthplace *(Stete or Foreign Country)*: Michigan

Usual Residence of Decedent

10a. Stete: Md.
10b. County: Baltimore
10c. City, Town or Location: Arbutus
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Sfreef and Number: 1226 Circle Drive
10f. Zip Code: 21227
10g. Citizen of What Country?: U.S.A.

11. Maritai Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedenf Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American indien, Bleck, White, etc. Specify: white

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Stock Broker
16b. Kind of Business/Industry: Stock Exchange

17. Fether's Neme *(First, Middle, Last)*: Herman J. Leinius
18. Mother's Name *(First, Middle, Meiden Surneme)*: Martha Sichard

19e. Informent's Neme/Relationship *(Type, Print)*: Jack Guenthner Nephew
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: Box 216 Casselton, North Dakota

20e. Method of Disposition: 1☒ Burial 2☐ Cremefion 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other pleca)*: Loudon Park Cemetery — Dete: 5-21-98
20c. Location - City or Town, Stete: Baltimore

21. Signeture of Funerel Service Licensee
22. Neme end Address of Fecility: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd, Balto. md. 21227

Physician /Medical Examiner

23e. Pert I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert feilure. List *only* one ceuse on each line. — Approximete Interval Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in death): e. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Lest:
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to compleflon of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☒ Yes 2☐ No

28. Piece of Deeth *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as steted. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: E.P. Williamson M.D.
29c. License number: D11171
29d. Dete signed *(Month, Day, Year)*: MAY 18, 1998

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): E.P. WILLIAMSON 405 FREDERICK ROAD CATONSVILLE 21228 MARYLAND

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: MAY 26 1998
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after deeth.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit.

10

ADH
98-2885-510
SHA'KI MURPHY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene — Certificate of Death

98 16217

Items: 23 part I,27 per MEO G-760 6/10/98 rev

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Daath Month / Day / Yaar	3. Tima of Death
SHA'KI	JO'SEPH	MURPHY	MAY 20, 1998	11:35 AM

4a. Facility Nama (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Daath
JOHNS HOPKINS BAYVIEW HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Aga (In yrs. last birthday)	If Under 1 Yaar: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
N/A	1☑M 2☐F	0 Yrs.		4	MAY 16, 1998	MARYLAND

Usuei Rasidenca of Decedant

10a. Stata	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	N/A	BALTIMORE CITY	1☑Yas 2☐No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
53 SERPENS COURT	21234	USA

11. Maritai Stetus	12. Wes Decedent Evar in U.S. Armed Forcas?	13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.)	14. Race - American Indian, Black, Whita, atc.
1☑Never Married 2☐Married 3☐Widowed 4☐Divorcad	1☐Yes 2☑No If Yes, Giva Yaer or Detes:	1☐Yas 2☑No Specify:	Specify: BLACK

15. Dacedant's Education (Specify only highast grada completed)		16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa ratired)	16b. Kind of Businass/Industry
Elamantary/Secondary (0-12)	Collaga (1-4or 5+)		
0		N/A	N/A

17. Father's Nama (First, Middle, Last)	18. Mothar's Nama (First, Middla, Maidan Surnama)
JOSEPH JOHN MURPHY	CHERYL BONNER

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)
JOSEPH MURPHY/CHERYL BONNER (FATHER & MOTHER)	334 S. SPRING CT., BALTIMORE, MD. 21231

20a. Mathod of Disposition	20b. Placa of Disposition (Nama of camatary, cramatory or othar placa)	Data	20c. Location - City or Town, Stata
1☑Burial 2☐Cramation 3☐Ramoval from State 4☐Donetion 5☐Othar (Specify)	KING MEMORIAL PARK	5-27-98	WOODLAWN, MARYLAND

21. Signeture of Funeral Service Licansee: ▶ Richard D. Brown

22. Nama and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one cause on each lina.

Approximata Intarval Batwaen Onsat and Daath

Immediata Causa (Final disaasa or condition rasulting in death)
a. KERNICTERUS

Dua to (or as a consaquanca of):

Saquantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiatad avants rasulting in death) Last
b.
Dua to (or as a consaquanca of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?
1☑Yas 2☐No	1☑Yas 2☐No

25. Was casa rafarrad to medical examiner?	26. Placa of Death (Check only ona)	
☒Yas 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Othar: 4☐Nursing Homa 5☐Rasidanca 6☐Othar (Specify)

27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Panding investigation 6☐Could not be datarmined		M	1☐Yas 2☐No	
	28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)			28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one)
1☐ **Certifying Physician:** To tha best of my knowledga, death occurrad at tha tima, data and place, and dua to tha causa(s) and mannar as stated.
☒ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurrad at tha tima, data and place, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of cartifiar	29c. Licansa number	29d. Data signed (Month, Day, Year)
▶ Margarita Korell	OCME	MAY 21, 1998

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print)
Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Yaar)	32. Registrar's Signatura
MAY 26 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16218

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM JOSEPH MASSEY, SR.

2. Date of Death: Month MAY; Day 13; Year 1998

3. Time of Death: 10:58 AM

4a. Facility Name *(If not institution, give street and number)*: 7419 Back Street

4b. City, Town, or Location of Death: Newcomb

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: unknown

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 26, 1917

9. Birthplace *(State or Foreign Country)*: unknown

Usual Residence of Decedent

10a. State: unknown

10b. County: unknown

10c. City, Town or Location: unknown

10d. Inside City Limits: 1☐ Yes 2☐ No unknown

10e. Street and Number: unknown

10f. Zip Code: unknown

10g. Citizen of What Country?: U.S.A.

11. Marital Status: unknown — 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? unknown — 1☐ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) — 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): unknown; College (1-4or 5+): unknown

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: unknown

16b. Kind of Business/Industry: unknown

17. Father's Name *(First, Middle, Last)*: unknown

18. Mother's Name *(First, Middle, Maiden Surname)*: unknown

19a. Informant's Name/Relationship *(Type, Print)*: Mary Davis/daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: unknown

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other *(Specify)* in state

20b. Place of Disposition *(Name of cemetery, crematory or other place)*:

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Joseph B. Van Sant

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Hypertensive Cardiovascular Disease with Renal Insufficiency — 10yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Carotid Stenosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*:

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*:

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ William H Wood Jr. MD

29c. License number: D58715

29d. Date signed *(Month, Day, Year)*: 5/13/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): WILLIAM H WOOD JR. EASTON, MD 21601

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16219

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles Maxwell
2. Date of Death Month / Day / Year: MAY 17 1998
3. Time of Death: 8:50p.m
4a. Facility Name *(If not institution, give street and number)*: GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 235-18-1149
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
6. Date of Birth *(Month, Day, Year)*: April 27, 1915
9. Birthplace *(State or Foreign Country)*: unknown

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6951 Copperbend Lane
10f. Zip Code: 21209
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? unknown 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): unknown; College (1-4or 5+): unknown
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: unknown
16b. Kind of Business/Industry: unknown

17. Father's Name *(First, Middle, Last)*: unknown
18. Mother's Name *(First, Middle, Maiden Surname)*: unknown

19a. Informant's Name/Relationship *(Type, Print)*: Jack Maxwell/brother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: unknown

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other *(Specify)* in state
20b. Place of Disposition *(Name of cemetery, crematory or other place)*:
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Joseph B. Van Sant
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. pneumonia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
renal failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thomas F. Lansdale MD
29c. License number: D43936
29d. Date signed *(Month, Day, Year)*: 5/18/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THOMAS F. LANSDALE M.D. 6505 N. Charles St. Baltimore MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998
32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Maxwell, Charles

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5:50 pm May 18, 1998

Manelis, Kenneth

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16220

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
KENNETH	ROBERT	MANELIS	MAY	18	1998	5:50PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HOSPICE OF BALTO. - GILCHRIST CENTER	TOWSON	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
110-38-5360	1☐M 2☐F	48 Yrs.					DEC. 18, 1949	NEW YORK

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
846 MILFORD MILL RD.	21208	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5	NEWS ANCHOR	RADIO

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
EDWARD	MANELIS	JULIA	PUTRIM

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SIGRID DREYFUSS-MANELIS (WIFE)	846 MILFORD MILL RD BALTO., MD 21208

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	HAR SINAI	5/21/98	OWINGS MILLS, MD

21. Signature of Funeral Service License ▶ [signature]

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Liver cancer	6 weeks
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ N. Anthony Riley, MD	D25205	MAY 19, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 26 1998	▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 16221

Item#7 per FH G759 5/26/98 FW

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Beulah Jefer Mitchell

2. Date of Death: Month: May; Day: 2; Year: 1998

3. Time of Death: 10:12 Pm

4a. Facility Name (If not institution, give street and number): Rock Glen Nursing Home & Rehab

4b. City, Town, or Location of Death: Baltimore Maryland

4c. County of Death: U.S.A

Funeral Director

5. Social Security Number: 578-28-6049

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 80 ~~81~~ Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 11, 1917

9. Birthplace (State or Foreign Country): U.S.A

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 10 ROCK GLEN ROAD

10f. Zip Code: 21213

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7TH; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC WORKER

16b. Kind of Business/Industry: UNAVAILABLE

17. Father's Name (First, Middle, Last): STEVEN JETER

18. Mother's Name (First, Middle, Maiden Surname): MARY GILLIAM

19a. Informant's Name/Relationship (Type, Print): ANNIE R. JETER-SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3324 CLAY STREET,NE WASHINGTON, D.C. 20019

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): NORTHERN VIRGINIA CREM.

Date: MAY 11

20c. Location - City or Town, State: 98 ARLINGTON,VA.

21. Signature of Funeral Service Licensee: W.H. Bacon 276

22. Name and Address of Facility: W.H. BACON FUNERAL HOME INC. 3447 14TH STREET,NW WASHINGTON,D.C. 20010

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Coma — wks

Due to (or as a consequence of):
b. Encephalopathy - Anoxic VI Metabolic — wks.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia
CHF
Paranoid Behavior/Psychosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: B. J. U. RAKHIA, M.D.

29c. License number: D 36942

29d. Date signed (Month, Day, Year): 5/4/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B. J. U. RAKHIA, MD 1009, Frederick RD. BALTIMORE, MD 21228

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16222

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Louis Turfield Miller

2. Date of Death Month / Day / Year: MAY 24, 1998

3. Time of Death: 0036

4a. Facility Name *(If not institution, give street and number)*: St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 217-03-9667

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct 14 1912

9. Birthplace *(State or Foreign Country)*: MD.

Usual Residance of Decedent

10a. State: MD.

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1 ☐ Yes 2 ☑ No

10e. Street and Number: 408 South Rolling Road

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yas, specify Cuban, Mexicen, Puerto Rican, atc.): 1 ☐ Yes 2 ☒ No — Specify:

14. Race - American Indian, Black, White, etc. — Specify: white

15. Decedent's Education *(Specify only highest grade completed)*: Elamantary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: owner/operator aircraft over-haul business

16b. Kind of Business/Industry: air service

17. Father's Name *(First, Middle, Last)*: William L. Miller

18. Mother's Name *(First, Middle, Maiden Surname)*: Sadie Martin

19a. Informant's Name/Relationship *(Type, Print)*: Carole A. Crist, daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 236 Rollingbrook Way, Catonsville, Md. 21228

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Loudon Park Cemetery — Date: 5/27/98

20c. Location - City or Town, State: Catonsville, MD.

21. Signature of Funeral Service Licensee: ▶ Wanda L Lemmer

22. Name and Address of Facility: Witzke Funeral Home, Inc. 1630 Edmondson Ave., Catonsville, MD. 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. ACUTE Inferior Wall myocardial INFARC	3 hrs
Due to (or as a consequence of):	A. Fib	10 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):	Hypertension.	5 yrs.
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: PD 10874

29d. Date signed *(Month, Day, Year)*: MAY, 24, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ANthony R. DOT, 900 CATON AVE BALTIMORE, MD 21229

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998

32. Registrar's Signature: ▶ Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

NAME MILLER, LOUIS

15

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 10e Per FH Film G759 5-26-98 rja

Certificate of Death

Reg. No. 98 16223

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
RAISA MUDRIK			May	22	1998	9:35 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SINAI HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-94-2075	1☐ M 2☒ F	74 Yrs.					MAY 8, 1924	RUSSIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
~~3061~~ 3601 FORDS LA., APT. 606	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOME MAKER	OWN HOME

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
JOSEPH	KARASIK	VERA	KIRPICHNIKOV

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
ISAAK MUDRIK (HUS.)	3601 FORDS LA., APT. 606	BALTO., MD 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	HAR SINAI	5/24/98	OWINGS MILLS, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cerebrovascular accident	
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	AS240232I-SL-9009	May 22, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAMUEL LEE, SINAI HOSPITAL

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 26 1998	[signature] Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16224

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Edward Eugene Mann, Jr.	May 21, 1998	2:14 p.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Franklin Square Hospital	Rossville	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-26-6655	1☒ M 2☐ F	68 Yrs.			Dec. 22, 1929	Baltimore, Md.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	N/A	Baltimore City	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3015 Harview Avenue	21234	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
5		Public Works	City of Baltimore

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Edward E. Mann Sr.	Ella Milstread

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Patricia A. Mann (Wife)	3015 Harview Avenue Baltimore, Maryland 21234

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Hilltop Service Corp.	5/23/98	Towson, Maryland

21. Signature of Funeral Service Licensee: Milton J Knight Jr. ▸ Milton J Knight Jr.

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Aspiration Pneumonia

Due to (or as a consequence of):
b. Peripheral Vascular disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Depression

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
▸ Jnicah Tripuraneni	D 30661	May 22nd 98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Sireesh Tripuraneni 5601 Loch Raven Blvd Balto md 21239

To the Registrar Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

5

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 26 1998	▸ Gina Burden-Randall

DHMH 16 Rev 6/95

98-2840-005
DDG
JOHNATHAN NILES

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16225

Items: 23 part I,27,28a-f per MEO G-760 6/10/98 reb.

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Jonathan Terrence Niles	MAY 18, 1998	9:32 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTHWEST HOSPITAL-EMERGENCY ROOM	RANDALLSTOWN	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-08-4222	XX 1 M 2 F	13 Yrs.			March 24, 1985	Md.

Usual Residance of Decedant

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Randallstown	1 Yes XX 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8405 Allenswood Road	21133	USA

11. Marital Status	12. Was Decedant Ever in U.S. Armed Forces?	13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
XX 1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes XX 2 No If Yes, Give Year or Dates:	1 Yes XX 2 No Specify:	Specify: Black

15. Decedant's Education (Specify only highest grade completed)		16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
7th Grade		Student	Old Court Middle School

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ronald A. Niles	Tracey Smith

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ronald A. Niles father	8405 Allenswood Road Randallstown, Md. 21133

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, cramatory or other place)	Date	20c. Location - City or Town, State
XX 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Druid Ridge Cemetery	May 23	Pikesville, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Ernest R. Perry Jr.	Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. DROWNING	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 XX No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 XX Yes 2 No	XX Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 XX Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 5 Pending investigation XX Accident 3 Suicide 6 Could not be determined 4 Homicide	5/18/98	8:20 P M	1 Yes XX No	Subject drowned

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Swimming pool	3714 Courtleigh Dr. Randallstown, Md.

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 XX **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J. Aaron Locke MD	O.C.M.E.	MAY 20, 1998

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
J. AARON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 26 1998	Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16226

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Nance

2. Date of Death (Month, Day, Year): May 24th 1998

3. Time of Death: 6:00am

4a. Facility Name (If not institution, give street and number): Liberty Medical

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-02-1490

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 25, 1914

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4008 Kathland Ave.

10f. Zip Code: 21207

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Negro

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Food Service

16b. Kind of Business/Industry: Public Schools

17. Father's Name (First, Middle, Last): Stacey Williams

18. Mother's Name (First, Middle, Maiden Surname): Carrie Williams

19a. Informant's Name/Relationship (Type, Print): Ms. Sarah Byrd (niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4404 Kathland Ave. Balto. Md. 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Voshell Mem. Gardens | Date: 5/28/98

20c. Location - City or Town, State: Dundalk, Md.

21. Signature of Funeral Service Licensee: Joseph L. Kuss

22. Name and Address of Facility: Joseph L. Kuss Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Renal Failure

Due to (or as a consequence of):

c. Congestive Heart Failure

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Hanan Alder House officer

29c. License number: 038993

29d. Date signed (Month, Day, Year): 05/24/98.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hanan Alder MD 2600 liberty Hghts Baltimore MD 21215

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 16227

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: JOHN O'BRIEN

2. Data of Daath — Month: MAY — Day: 24, — Yaar: 1998

3. Tima of Daath: 3:45 PM

4a. Facility Nama *(If not institution, giva straat and numbar)*: RIDGEWAY MANOR NURSING HOME

4b. City, Town, or Location of Death: CATONSVILLE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Numbar: 086-07-1582

6. Sax: XX M 2☐ F

7. Aga *(In yrs. last birthday)*: 93 Yrs.

If Undar 1 Yaar — Months: Deys:

If Undar 24 Hrs. — Hours: Min.:

8. Data of Birth *(Month, Day, Yaar)*: 11/07/1904

9. Birthplaca *(Stata or Foraign Country)*: IRELAND

Usual Rasidance of Dacadant

10a. Stata: MD

10b. County: BALTIMORE

10c. City, Town or Location: CATONSVILLE

10d. Insida City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5717 EDMONDSON AVENUE

10f. Zip Coda: 21228

10g. Citizan of What Country?: U.S.A.

11. Maritel Stetus: 1☐ Naver Married XX Marriad 3☐ Widowed 4☐ Divorced

12. Was Dacedent Ever in U.S. Armed Forcas? 1☐ Yas 2XX No — If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxicen, Puarto Rican, atc.): 1☐ Yas 2XX No *Specify:*

14. Race - Amarican Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Educetion *(Spacify only highast greda completed)*: Elementery/Secondery (0-12): 12 — Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: INSPECTOR

16b. Kind of Businass/Industry: NEW YORK CITY TRANSIT COMPANY

17. Fathar's Name *(First, Middle, Last)*: HUGH O'BRIEN

18. Mothar's Nama *(First, Middle, Maidan Surnama)*: MARY FEE

19a. Informant's Name/Relationship *(Type, Print)*: MARION B. CORRY/DAUGHTER

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 419 DRURY LANE, BALTIMORE, MARYLAND 21229

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Spacify)*

20b. Place of Disposition *(Nama of cemetery, cramatory or othar place)*: NEW CATHEDRAL CEMETERY

Data: 5/27/98

20c. Location - City or Town, Stete: BALTIMORE, MARYLAND

21. Signatura of Funeral Service Licensaa: Phillip Hasler

22. Nama and Address of Facility: STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not enter the moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one ceuse on aach lina.

Approximate Interval Batween Onsat and Death

Immediata Cause (Finat disaasa or condition resulting in daath): a. Arteriosclerotic cardiovascular disease — 10 years

Due to (or as a consequence of):

Sequantially list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avents resulting in death) Last:

b.

Due to (or as a consaquance of):

c.

Dua to (or as a consequenca of):

d.

Part II. **Othar significant conditiona** contributing to death but not rasulting in tha undarlying ceusa givan in Part I.

Gastroparesis
senile dementia
chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Wara autopsy findings available prior to completion of ceusa of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical exeminer? 1☐ Yas 2☑ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Homa 5☐ Rasidance 6☐ Other *(Specify)*

27. Mennar of Deeth: 1☑ Naturel 2☐ Accidant 3☐ Suicida 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be datarminad

28a. Dete of Injury *(Month, Dey Yaar)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, streat, factory, office building, atc. *(Spacify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☑ **Certifying Physician:** To tha best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) and mennar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar stated.

29b. Signatura end titla of certifiar: Damian E. Birkess MD

29c. Licansa number: D22114

29d. Dete signed *(Month, Day, Yaar)*: 5/26/98

30. Name end eddress of person who completed ceusa of daath (Item 23a) (Type, Print): DAMIAN E. BIRKESS MD — 5411 OLD FREDERICK RD, #18 BALTIMORE, MD 21229

State Registrar

31. Data filed *(Month, Day, Yaar)*: MAY 26 1998

32. Registrer's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16228

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: ROBERT LEE PLAYER

2. Dete of Deeth — Month: May Day: 19 Yeer: 1998

3. Time of Death: 2250

4a. Facility Neme *(If not institution, give street end number)*: Deaton University of Maryland Medicine

4b. City, Town, or Location of Death: Baltimore

4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 250-01-9171

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Deta of Birth *(Month, Dey, Yeer)*: MAY 4, 1909

9. Birthplace *(State or Foreign Country)*: SOUTH CAROLINA

Usuel Residence of Decedent

10a. Stete: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street end Number: 2303 SIDNEY AVENUE

10f. Zip Code: 21230

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes [X] No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - Amerlcan Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 7th grade — College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: DIET AID

16b. Kind of Business/Industry: SOUTH BALTIMORE HOSP.

17. Fether's Neme *(First, Middle, Last)*: WILL BROWN

18. Mother's Name *(First, Middle, Maiden Surneme)*: SARAH BROWN

19e. Informent's Neme/Reletionship *(Type, Print)*: Mildred Player/ Wife

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 2303 SIDNEY AVENUE, BALTIMORE, MARYLAND 21230

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from Steta 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Pleca of Disposition *(Neme of cemetery, cremetory or other pleca)*: MT. ZION CEMETERY

Dete: 5-26-98

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signeture of Funeral Servica Licensee: Hari G. Clore

22. Neme end Address of Feciility: WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE

Robert Lee Player
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Deeth

Immediete Ceuse (Final disease or condition resulting in deeth)

e. Sepsis

Due to (or es e consequence of):

b. Bacteremia (lactobacillus)

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest

Due to (or es e consequence of):

c.

Due to (or es e consequenca of):

d.

Pert It. **Other slgnificant conditiona** contributing to death but not resulting in the underlying cause given In Pert I.

Dementia of uncertain etrology

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings availeble prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Plece of Deeth *(Check only one)*

Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA

Other: 4 [X] Nursing Home 5 [ ] Residenca 6 [ ] Other *(Specify)*

27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medicat Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end plece, end due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: George Taler MD

29c. License number: D19858

29d. Dete signed *(Month, Day, Year)*: May 20, 1998

30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): George Taler, M.D. 611 S. Charles St. Baltimore, Md. 21230

31. Date filed *(Month, Day, Yeer)*: MAY 26 1998

32. Registrer's Signetura: Juliet Davidson-Randall

State Registrar

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit.

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16229

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALTA RAE POFFENBERGER
2. Date of Death: Month May Day 21 Year 98
3. Time of Death: 08:55
4a. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 186-03-2097
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 17, 1914
9. Birthplace (State or Foreign Country): Kansas

Usual Residence of Decedent

10a. State: MD
10b. County: A.A. CO.
10c. City, Town or Location: CROFTON
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1557 FARLOW AVE.
10f. Zip Code: 21114
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 03
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE
16b. Kind of Business/Industry: UNKNOWN
17. Father's Neme (First, Middle, Last): UNKNOWN
18. Mother's Name (First, Middle, Maiden Sumeme): UNKNOWN
19a. Informant's Name/Relationship (Type, Print): John T. Poffenberger - Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1557 Farlow Avenue, Crofton, MD 21114
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National
Dete: 05/28
20c. Location - City or Town, State: Arlington, VA
21. Signature of Funeral Service Licensee: Patrick J Arnold Jr.
22. Name end Address of Feciility: HARDESTY FUNERAL HOME P.A. 851 ANNAPOLIS RD, GAMBRILLS MD. 21054

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting In death) a.	Hypertensive Cardiac Disease	10yrs
Due to (or as a consequence of):		
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last — b.	Hyperlipidemia	5yrs
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given In Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion ot cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D0051304
29d. Dete signed (Month, Day, Year): 5/22/98

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Hoon Kim Kimbrough Army hospital Ft. Meade, Md 20755

State Registrar

31. Dete filed (Month, Day, Year): MAY 26 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet tha death certificate be executed within 24 hours eftar death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16230

Item 19a, 20a per FH Film G759 5-26-98 rja

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eleanor F. PLOVSKY
2. Date of Death: Month May, Day 18, Year 1998
3. Time of Death: 6-40PM
4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 212-09-3546
8. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN 7, 1919
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10e. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13 RANDALL AVE.
10f. Zip Code: 21208
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME
17. Father's Name (First, Middle, Last): SAMUEL FINE
18. Mother's Name (First, Middle, Maiden Surname): IDA Feldman
19a. Informant's Name/Relationship (Type, Print): MRS. ROSALIND ~~TAYLORE~~ Taylor (DAUG.)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8601 VICTORIA RD. SPRINGFIELD, VA 22151
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ ~~Removal~~ from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BNAI ISRAEL CONG.
Date: 5/22/98
20c. Location - City or Town, State: BALTIMORE, MD
21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	METASTATIC CARCINOMA	18 months.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	LARGE CELL LYMPHOMA	2 years.
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION
Non-Insulin Dependant Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No
25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): N/A
28b. Time of Injury: N/A M
28c. Injury at Work? 1☐ Yes 2☑ No
28d. Describe how injury occurred: N/A
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): N/A
28f. Location (Street and Number or Rural Route Number, City or Town, State): N/A.

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of Certifier: N.B. Vellanki
29c. License number: D.30469
29d. Date signed (Month, Day, Year): May 18, 1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): N.B. VELLANKI, M.D. 9055, CHEVROLET DRIVE; # 100; ELLICOTT CITY; MD 21042

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998
32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 98-6231

State of Maryland / Department of Health and Mental Hygiene

Item#20b per FH G759 5/26/98 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Paulette PAYNE
2. Date of Death: Month MAY Day 21 Year 1998
3. Time of Death: 3:05pm
4e. Facility Name (If not institution, give street and number): 2104 Third Avenue
4b. City, Town, or Location of Death: Woodlawn
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-46-4782
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 48 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5-29-1949
9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Woodlawn
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2104 Third Avenue
10f. Zip Code: 21207
10g. Citizen of What Country? U.S.A

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Word Processor
16b. Kind of Business/Industry: Johns Hopkins

17. Father's Name (First, Middle, Last): Elbert Williams
18. Mother's Name (First, Middle, Maiden Surname): Juanita Thomas

19a. Informant's Name/Relationship (Type, Print): Daughter Deltrese Henson Winston
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2104 Third Avenue Baltimore, Md 21207

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 5-23-98
20c. Location - City or Town, State: Catonsville, Md

21. Signature of Funeral Service Licensee: Jerome A. Thompson
22. Name and Address of Facility: Mark F.H. West 4300 Wabash Avenue Balto, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. AIDS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M Boursiquot MD
29c. License number: BB5529031
29d. Date signed (Month, Day, Year): May 21, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARIE BOURSIQUOT, MD TWO KNOLL NORTH DRIVE COLUMBIA MD 21044

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998
32. Registrar's Signature: Julia Davidson-Kendall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16232

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Leo Joseph Pellegrine
2. Date of Death Month Day Year: May 17, 1998
3. Time of Death: 4:22 PM
4a. Facility Name *(If not institution, give street and number)*: 243 S. Castle Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-16-0991
6. Sex: 1 XX M 2 ☐ F
7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 01/23/1924
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☐ Yes 2 XX No
10e. Street and Number: 243 S. Castle Street
10f. Zip Code: 21231
10g. Citizen of What Country?: USA

11. Meritel Status: 1 ☐ Never Married XX Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 ☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 3 XX No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 6th; College (1-4or 5+):
18a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver
16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Carmine Pellegrini
18. Mother's Name *(First, Middle, Maiden Surname)*: Virginia Mazzola

19a. Informant's Name/Relationship *(Type, Print)*: Dorothy Pellegrine / Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 243 S. Castle Street Baltimore, Maryland 21231

20e. Method of Disposition: 1 XX Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: Sacred Heart of Jesus
Date: 5/22/98
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: David J. Weber
22. Name end Address of Facility: David J. Weber Funeral Home 401 S. Chester Street Baltimore, Maryland 21231

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in deeth)
e. Parkinson's disease.

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last
b. Polycythemia vera

Due to (or as a consequenca of):
c. hip fracture

Due to (or as a consequenca of):
d. Coronary artery disease

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
C-difficile Colitis
Dementia
HTN

23b. Did tobacco use contributs to the causs of death? 1 ☐ Yes 2 XX No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 XX No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 XX No

28. Piece of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 XX Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 XX Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Placa of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 XX **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Caplan M.D.
29c. License number: D0051156
29d. Date signed *(Month, Day, Year)*: 5/20/98

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): INA CAPLAN M.D. BEACHAM GERIATRICS Cente, BALTIMORE, 21224

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998
32. Registrar's Signature: Gina Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16233

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LIZZIE RAGIN

2. Date of Death *(Month, Day, Year)*: MAY 19 1998

3. Time of Death: 11:25 P

4a. Facility Name *(If not institution, give street and number)*: BON SECOUR HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-28-3915

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JUN 30 1928

9. Birthplace *(State or Foreign Country)*: NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2231 W. BALTIMORE STREET

10f. Zip Code: 21223

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th grade | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: FLORIST

16b. Kind of Business/Industry: FLOWERS

17. Father's Name *(First, Middle, Last)*: JOE LEE

18. Mother's Name *(First, Middle, Maiden Surname)*: MARTHA LEE

19a. Informant's Name/Relationship *(Type, Print)*: Gary Ragin/Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2231 W. Baltimore Street, Baltimore, Maryland 21223

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: WOODLAWN CEMETERY

Date: 5-26-98

20c. Location - City or Town, State: WOODLAWN, MARYLAND

21. Signature of Funeral Service Licensee: Juan C. Clore

22. Name and Address of Facility: WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Septicemia

Due to (or as a consequence of):
b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: End stage Renal Disease; Congestive Heart Failure; Hypertensive arteriosclerotic Heart Disease

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D16263

29d. Date signed *(Month, Day, Year)*: May 20, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JUAN A. BELTRAN, MD 1940 W. BALT ST, BALT. MD 21223

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16234

RAWLINGS, RONALD

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RONALD LEE RAWLINGS
2. Date of Death: Month MAY Day 21 Year 1998
3. Time of Death: 7:35 PM
4a. Facility Name (If not institution, give street and number): CATON MANOR NURSING HOME
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: UNKNOWN
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 56 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APRIL 17, 1942
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1820 ST. PAUL STREET
10f. Zip Code: 21202
10g. Citizen of What Country? USA.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 2 YRS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR
16b. Kind of Business/Industry: UNIVERSITY OF MD.

17. Father's Name (First, Middle, Last): JAMES O. RAWLINGS
18. Mother's Name (First, Middle, Maiden Surname): VIOLA JOHNSON

19a. Informant's Name/Relationship (Type, Print): RHONDA RAWLINGS-GIBSON DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1112 CHERRY HILL RD, APT J, BALTIMORE, MD. 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY Date: 5-26-98
20c. Location - City or Town, State: LANSDOWNE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIMORE, MD. 21217

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Acquired Immunodeficiency Syndrome — 2 Years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] Attending Doctor
29c. License number: D21684
29d. Date signed (Month, Day, Year): 5-22-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. CYRIAC M.D 8109 RITCHIE HWY, PASADENA, MD 21122

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16235

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM OTHA ROBINSON
2. Date of Death: Month MAY Day 21 Year 1998
3. Time of Death: 1407 Hrs.
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-34-8402
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 24, 1938
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. Stete: Md.
10b. County: Baltimore
10c. City, Town or Location: Randallstown
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3639 Cliftmar Road
10f. Zip Code: 21244
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machine Operator
16b. Kind of Business/Industry: Black & Decker Corp.

17. Fether's Name (First, Middle, Last): William Otha Robinson Sr.
18. Mother's Name (First, Middle, Maiden Sumame): Esther L. Branch

19a. Informant's Name/Retationship (Type, Print): Jean C. Robinson wife
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3639 Cliftmar Road Randallstown, Md. 21244

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Veterans
Date: May 28
20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funeral Service Licensee: Ernest L. Kerry Jr.
22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feiture. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. ANOXIC ENCEPHALOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest
b.
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: LARYNGEAL CARCINOMA

23b. Did tobacco use contribute to the cauee of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Sulcide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how Injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier: C. Ravi MD
29c. License number: D37333
29d. Date signed (Month, Day, Year): MAY 21, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): C. RAVI MD, NHC, BALTO. MD 21133

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998
32. Registrar's Signature: Judith Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

6+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16236

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY J. RODWELL

2. Date of Death — Month: May Day: 20 Year: 1998

3. Time of Death: 3:40 P.M.

4a. Facility Name *(If not Institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 216-22-4222

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 11/16/1916

9. Birthplace *(State or Foreign Country)*: NORTH CAROLINA

Usual Residence of Decedent

10a. State: MD

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 909 ANDREWS ROAD

10f. Zip Code: 21060

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: RETAIL SALES

16b. Kind of Business/Industry: DEPARTMENT STORE

17. Father's Name *(First, Middle, Last)*: JOHN L. BREEDLOVE

18. Mother's Name *(First, Middle, Maiden Surname)*: ROXIE UNKNOWN

19a. Informant's Name/Relationship *(Type, Print)*: JOHN H. RODWELL, SR. - HUSBAND

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 909 ANDREWS ROAD, GLEN BURNIE, MD 21060

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GLEN HAVEN MEM. PK.

Date: 5/23

20c. Location - City or Town, State: GLEN BURNIE, MD

21. Signature of Funeral Service Licensee: Thomas J. Sparda Jr.

22. Name and Address of Facility: RAYMOND C. FINK FUNERAL HOME OF GLEN BURNIE 426 CRAIN HWY., S.W, (AT 5TH AVE)MD, 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE lung disease

Due to (or as a consequence of):

b. ASPIRATION PNEUMONIA.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D43977

29d. Date signed *(Month, Day, Year)*: May 20 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AYUOKA OKETUNJI. 301 Hospital Drive, Glen Burnie. MD 21061

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Mary J. Rodwell

RC

16

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16237

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY HELEN ROBINSON
2. Data of Death: Monih 5 Dey 20 Year 1998
3. Time of Death: 10:03 P.M.
4a. Facility Name (If not institution, give street and number): MARINER HEALTH OF FOREST HILL
4b. City, Town, or Location of Death: FOREST HILL
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 230-66-8131
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06 15 1904
9. Birthplace (State or Foreign Country): Virginia

Usuei Residence of Decedent

10a. State: Md. | 10b. County: Nk | 10c. City, Town or Location: Baltimore | 10d. inside City Limits: 1☒ Yes 2☐ No

10e. Streei and Number: 3707 Chatham Rd. | 10f. Zip Code: 21215 | 10g. Citizen of Whet Country? USA

11. Marital Staius: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Wes Decedeni Ever In U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indien, Bleck, Whiie, etc. Specify: Negro

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+): 0
16e. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired): Homemaker
16b. Kind of Business/Industry: own Home

17. Father's Name (First, Middle, Last): Linwood L. Jeter
18. Mother's Name (First, Middle, Maiden Surname): Emma Jeter

19a. Informant's Name/Relaiionship (Type, Print): James E. Ford Sr (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3707 Chatman Rd. Baltimore, Md. 21215

20e. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cem. | Date: 5/26/98 | 20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave, Baltimore, Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thei caused the deeth. Do noi enter the moda of dying, such as cardiac or respiretory arrest, shock, or heert failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Deeth
Immediele Cause (Finei disease or condition resulting in deeth)	a. Cerebrovascular disease	3 years
Sequentially iisi conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as e consequence of):	
	d.	

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.: coronary artery disease hypertension

23b. Did tobecco uee contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyeician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or Investigetion, in my opinion, deeth occurred at the time, data end pieca, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: 028339
29d. Date signed (Month, Day, Year): May 21, 1998

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): UNDA. FREICHT 101E Wood Road Balto MD 21015

State Registrar

31. Dete filed (Month, Dey, Year): MAY 26 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 98-6238

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Item#26 per Phy G759 5/26/98 EW

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bernadine Ramsey

2. Date of Death Month / Day / Year: May 21 1998

3. Time of Death: 8:45 am

4a. Facility Name *(If not institution, give street and number)*: 1308 Harbor Road

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218-03-5447

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 13, 1915

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 701 Glenwood Apt. 412

10f. Zip Code: 21401

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Entrepreneur

16b. Kind of Business/Industry: Self-Employed

17. Father's Name *(First, Middle, Last)*: Joseph Hickman

18. Mother's Name *(First, Middle, Meiden Surname)*: Martha Amos

19a. Informant's Name/Relationship *(Type, Print)*: Martha Hadaway - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1308 Harbor Road, Annapolis, MD 21403

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory

Date: 05/22

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Kimberly S. Rose

22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CEREBROVASCULAR DISEASE

CHRONIC RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)* Daughter's Residence

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD MPH

29c. License number: 038328

29d. Date signed *(Month, Day, Year)*: 5/21/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mary R. Clance, MD, 180 Admiral Cochrane Drive, Annapolis, Md 21401

State Registrar

31. Date filed *(Month, Dey, Year)*: MAY 26 1998

32. Registrar: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16239

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)	3. Time of Death
ANNA		ROFF	MAY 20, 1998	4:30am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MERIDIAN BRIGHTWOOD NURSING HOME	LUTHERVILLE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-12-9265	1☐ M 2☒ F	76 Yrs.					AUG. 16, 1921	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
130 SLADE AVE., APT. 212	21208	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		PROCESSOR	STATE OF MARYLAND

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
JACOB	ROFF	MARY	HORNER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MRS. ILENE COHEN (COUSIN)	2408 SUGARCONE RD. BALTIMORE, MD 21208

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	HAR ZION TIFERETH ISRAEL	5/21/98	ROSEDALE, MD

21. Signature of Funeral Service Licensee: Michael Berger

22. Name and Address of Facility: Sol Levinson & Bros., Inc. 8900 Reisterstown Road Baltimore, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Cardiopulmonary arrest	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Respiratory failure	
	Due to (or as a consequence of):	
	c. Hypoventilation syndrome	
	Due to (or as a consequence of):	
	d. Sleep apnea	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D 30339	5/20/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Milan WIKTER, MD 4000 Old Court Rd. Baltimore, MD 21208

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 26 1998	▶ Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

RB

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16240

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: IDA C. RUBIN
2. Date of Death Month: May Day: 22 Year: 1998
3. Time of Death: 6:05 a.m.
4a. Facility Name *(If not institution, giva street and number)*: STELLA MARIS HOSPICE
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Numbar: 219-30-9011
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 97 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: NOV. 11, 1900
9. Birthplece *(Stete or Foreign Country)*: MARYLAND

Usuel Residence of Decedent

10a. Stata: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street end Number: 1500 BEDFORD AVE, APT. 410
10f. Zip Code: 21208
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decadent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:* X
14. Race - Amarican Indian, Bieck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: SEAMSTRESS
16b. Kind of Business/Industry: GARMENT

17. Fathar's Nama *(First, Middle, Last)*: JACOB COHEN
18. Mother's Neme *(First, Middle, Maiden Surname)*: LENA ZELDISH

19e. Informent's Name/Relationship *(Type, Print)*: MR. RONALD RUBIN (SON)
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 725 KAHN DRIVE BALTIMORE, MD 21208

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: ANSH EMUNAH | Date: 5-24-1998
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funerel Service Licensee: Ellenore Levinson Jeffers
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD BALTIMORE, MD 21208

Physician /Medical Examiner

23e. Pert1. Enter the disease, or compiicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line. | Approximete Interval Between Onset and Deeth

Immediate Cause (Finel diseese or condition resulting in deeth): e. Pancreatic Cancer
Due to (or es e consequence of):
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last:
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yas 2☒ No
24b. Were eutopsy findings eveileble prior to compiation of cause of deeth? 1☐ Yas 2☐ No

25. Wes case referred to medical examiner? 1☐ Yas 2☒ No

26. Placa of Daath *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Homa 5☐ Residence 6☒ Other *(Specify)* HOSPICE

27. Mannar of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Deta of Injury *(Month, Dey Yeer)*
28b. Tima of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, offica builiding, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: Edward MD
29c. License number: D44128
29d. Date signed *(Month, Dey, Year)*: 5/22/98

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): DR. PENELOPE EDWARDS 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed *(Month, Dey, Year)*: MAY 26 1998
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiena.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: Tha law requires that the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificete has been signed by the attending physician and completed by the funeral director, pege 2 should be detached for use es the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 / 16241

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leonard Resnick
2. Date of Death Month/Day/Year: May 20, 1998
3. Time of Death: 310 pm
4a. Facility Name (If not institution, give street and number): Sinai Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 213-12-0537
6. Sex: 1☐ M 2☐ F — X
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR. 13, 1922
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11 POMONA SOUTH, APT. 3
10f. Zip Code: 21208
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: WHITE

15. Decadent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): ENGRAVER
16b. Kind of Business/Industry: ENGRAVING

17. Father's Name (First, Middle, Last): WILLIAM RESNICK
18. Mother's Name (First, Middle, Maiden Surneme): CELIA ROSENBERG

19a. Informant's Name/Reiationship (Type, Print): ESTELLE RESNICK (WIFE)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 11 POMONA SOUTH, APT. 3 BALTO., MD 21208

20a. Method of Disposition: ☒1 Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): ARLINGTON (CHIZUK AMUNO)
Date: 5/22/98
20c. Location - City or Town, State: BALTO., MD

21. Signature of Funeral Service Licensee: Scott M. Cattle
22. Name end Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finei disease or condition resulting in death)
e. Sepsis
Due to (or es e consequence of):
b. Non Hodgkin's lymphoma

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequenca of):
c.
Due fo (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary artery disease
diabetes
Crohn's disease

23b. Did tobacco uee contribute to the cauus of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☑ Neturei 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Couid not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowiedge, death occurred at the time, dete end piaca, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, date and piace, and due to the ceuse(s) and manner stated.

29b. Signature end title of certifier: Usha Sunkara
29c. License number: D-21187
29d. Date signed (Month, Dey, Year): May 20, 1998

30. Neme and address ot person who completed cause of death (Item 23e) (Type, Print): Usha Sunkara MD, Sinai Hospital, 2401 W. Belvedere Ave, Baltimore

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998
32. Registrar's Signeture: Julia Davidson-Yandell

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

RB

15+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16242

Physician / Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Anna	Marie	Rozanski	May 20, 1998	1:00AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
5832 Edmondson Ave.	Catonsville	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-20-4296	1☐ M 2☑ F	70 Yrs.			11/05/1927	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Catonsville	1☐ Yes 2☑ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5832 Edmondson Ave.	21228	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☑ No If Yes, Give Year or Dates:	1☐ Yes 2☑ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Homemaker	Domestic

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert Forrester	Catherine Kroh

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Bernard N. Rozanski/Husband	5832 Edmondson Ave. Baltimore Md. 21228

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	New Cathedral Cemetery	05-22	Baltimore MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kathleen Weber CFSP	David J. Weber Funeral Home 5311 Edmondson Ave. Baltimore Md. 21229

Physician / Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarction	1hr.
Due to (or as a consequence of):	b. Atherosclerotic cardiovascular Disease	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		
Due to (or as a consequence of):	c. Renal Failure	
Due to (or as a consequence of):	d. Diabetes mellitus	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Edmund, Rand	D34451	5-21-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edmund P. Theriault 405 Frederick Rd Suite 100 Catonsville 21228

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 26 1998	▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16243

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDWARD LEE SPADY

2. Date of Death Month Day Year: MAY 21, 1998

3. Time of Death: 2:43 AM

4a. Facility Name (If not institution, give street and number): STELLA MARIS AT MERCY HOSPICE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-28-3692

6. Sex: 1☑ M 2☐ F

7. Age (In yrs. last birthday): 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MARCH 16, 1933

9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 2306 WHITTIER AVENUE

10f. Zip Code: 21217

10g. Citizen of What Country? USA.

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☑ Yes 2☐ No If Yes, Give Year or Dates: 5-18-53 5-10-55

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MACHINIST

16b. Kind of Business/Industry: MACHINE COMPANY

17. Father's Name (First, Middle, Last): MAJOR SPADY

18. Mother's Name (First, Middle, Maiden Surname): VERNA FETCHETT

19a. Informant's Name/Relationship (Type, Print): GLORIA THOMPSON (FRIEND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2206 ROSLYN AVENUE, BALTIMORE, MD. 21216

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST

Date: 5-27-98

20c. Location - City or Town, State: OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee: ▶ [signature] D. Brown

22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME, PA. 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC COLON CANCER — 3 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

prostate cancer

Depression

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) STELLA MARIS HOSPICE AT MERCY

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D40480

29d. Date signed (Month, Day, Year): May 21, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FERNANDO J. FERRO, MD 7672 Belair Rd Balto., MD 21236

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be secured within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760 Baltimore, Maryland 21215-0020

Edward Spady

5+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16244

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Agnes Sunderland

2. Date of Death: Month May Day 20 Year 98

3. Time of Death: 430 Am

4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death: COLUMBIA

4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 219-36-1969

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 98 Yrs.

If Under 1 Year: Months ___ Days ___

If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): 01/21/1900

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: HOWARD

10c. City, Town or Location: COLUMBIA

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5222 HERMIT PATH

10f. Zip Code: 21044

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bieck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): COMMISSIONER's SECRETARY

16b. Kind of Business/Industry: DEPARTMENT OF MOTOR VEHICLES

17. Father's Name (First, Middle, Last): CHARLES BUSEY

18. Mother's Name (First, Middle, Maiden Surneme): FLORENCE DENNY

19a. Informant's Name/Relationship (Type, Print): ANN S. EBERSBERGER/GRANDDAUGHTER

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12693 FOLLY QUARTER RD ELLICOTT CITY, MD 21042

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY

Date: 5/23/98

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Phillip Stark

22. Name end Address of Feciility: STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximate Intervei Between Onset end Death

Immediete Cause (Finai diseese or condition resulting in death)

e. Pneumonia — 3 days

Due to (or es e consequence of):

Sequentiaily list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

b. ___

Due to (or as a consequence of):

c. ___

Due to (or as a consequence of):

d. ___

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yss 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☑ No

26. Piace of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physiclen:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminer:** On the basis of examination end/or Investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier: Gary Brooks

29c. License number: 022587

29d. Date signed (Month, Day, Year): May 20, 1998

30. Name and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): Gary Brooks 11055 Little Patuxent Columbia, Maryland

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998

32. Registrar's Signeture: Lydia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16245

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEONARD J. SEEBACH, SR.

2. Date of Death (Month, Day, Year): MAY 22 1998

3. Time of Death: 7:40 PM

4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-18-3481

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 7 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore Highlands

10d. Inside City Limits: 1 [ ] Yes [X] No

10e. Street and Number: 3004 New York Ave.

10f. Zip Code: 21227

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - Americen Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+)

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Tool&Dye Machinist

16b. Kind of Business/Industry: Metal Fabrication

17. Father's Name (First, Middle, Last): Henry W. Seebach

18. Mother's Name (First, Middle, Maiden Surneme): Josephine Eber

19a. Informant's Name/Relationship (Type, Print): Leonard J. Seebach Jr.

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1524 Lodge Pole Ct. Annapolis, Md. 21401

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other place): Loudon Park Cemetery

Date: 5-26-98

20c. Location - City or Town, State: Baltimore

21. Signature of Funerel Service Licensee: Dean D. Ambrose

22. Name and Address of Facility: Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Maryland 21227

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final diseese or condition resulting in death) e.	LUNG CANCER	1 YEAR
Due to (or as a consequence of):		
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	BRAIN METASTATIC TUMOR	2 WEEKS
Due to (or as a consequence of):		
c.		
Due to (or as e consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part t.: HYPERTENSION

23b. Dtd tobacco use contribute to the cause of death? 1 [✓] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24e. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was cese referred to medical examiner? 1 [ ] Yas 2 [✓] No

26. Piece of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lizy B Thomas, MEDICAL RESIDENT

29c. Licensa number: AS 2441614-38

29d. Date signed (Month, Day, Year): MAY. 22-1996

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): LIZY. B. THOMAS, HARBOR HOSPITAL CENTER, BALTIMORE, MD.

State Registrar

31. Date filed (Month, Dey, Year): MAY 26 1998

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit.

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16246

Certificate of Death

Item: 15 per F.H. G-759 5/26/98 reb

Reg. No.

NAME: SMALLEY, KENNETH

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Kenneth Leroy Smalley	MAY 19, 1998	4:44PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
GREATER BALTIMORE MEDICAL CENTER	TOWSON	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
345-28-2261	1☐ M 2☐ F X	62 Yrs.			Dec. 31 1935	Illinois

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Parkton	1☐ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
17521 Masemore Road	21120	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yas, Give Year or Dates: '58-'60	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	~~n/a~~ 2	Project Mgr./Elec. Engineer	Communications

17. Father's Nema (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Stanley Smalley	Mae Lawick

19a. Informent's Neme/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Maryann Smalley/Wife	17521 Masemore Road/Parkton, MD 21120

20a. Mathod of Disposition	20b. Place of Disposition (Nema of cemetery, crematory or othar place) Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donetion 5☐ Other (Specify)	5/23/98 Dulaney Valley Memorial Gardens	Timonium, MD

21. Signature of Funaral Sarvice Licensee	22. Nama and Address of Facility
▶ Bryan W. Clary	Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
e. VENTRICULAR FIBRILLATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initiated events rasulting in death) Last
b. MYOCARDIAL INFARCTION

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part t.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes case refarred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yas 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Rasidance 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Invastigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, daath occurred at the time, deta and piace, and dua to tha cause(s) and manner steted.

29b. Signetura and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
▶ Michael D. Aressel, MD	D40547	5/21/98

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print)
MICHAEL D. ARESSEL, 6565 N. CHARLES ST., SUITE 305, BALTIMORE, MD 21204

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrar's Signeture
MAY 26 1998	▶ Julia Davidson-Randall

To be completed by the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

12X1

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16247

Certificate of Death

Items: 20a,b,c per F.H. G-759 5/26/98 reb

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JACQUELINE F. SPENCER

2. Date of Death Month Day Year: MAY 20, 1998

3. Time of Death: 6:40AM

4e Facility Name (If not institution, give street and number): 2205 ROGENE DRIVE, APT #202

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 127-26-1063

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT. 26, 1931

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 2205 ROGENE DRIVE, APT #202

10f. Zip Code: 21209

10g. Citizen of What Country? USA

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5+ College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER

16b. Kind of Business/Industry: BALTO. CITY PUBLIC SCHOOLS

17. Father's Name (First, Middle, Last): HOWARD F. SPENCER

18. Mother's Name (First, Middle, Maiden Surname): MARJORIE VALENTINE

19a. Informant's Name/Relationship (Type, Print): CAROL CARTER (COUSIN)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15 WYTCHWOOD CT. APT. #202, BALTIMORE, MD. 21209

20a. Method of Disposition: ~~1☑ Burial~~ 2☑ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY ~~ARBUTUS CEMETERY~~ Date: 5-21-98

20c. Location - City or Town, State: BALTIMORE, MD. ~~ARBUTUS, MARYLAND~~

21. Signature/Funeral Service Licensee: ▶ [signature] D. B

22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVENUE, BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CANCER OF PANCREAS — 1 MONTH

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D35606

29d. Date signed (Month, Day, Year): 5/20/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAMUEL HELFAND 21 CROSSPOINT DRIVE OWINGS MILLS MD 21117

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16248

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lashae Patrice Scott
2. Date of Death: Month: may Day: 8 Year: 1998
3. Time of Death: 3:30 Am
4a. Facility Name (If not institution, give street and number): Mercy Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: none
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): Yrs.
If Under 1 Year: Months: Days:
If Under 24 Hrs.: Hours: 5 Min.:
8. Date of Birth (Month, Day, Year): may 8, 1998
9. Birthplace (State or Foreign Country): maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2710 Lauretta Avenue
10f. Zip Code: 21223
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondery (0-12): none - 0
College (1-4or 5+): none - 0
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): none
16b. Kind of Business/Industry: none

17. Father's Neme (First, Middle, Lest): James Scott
18. Mother's Name (First, Middle, Melden Surneme): Katrina Patrice Thompson

19a. Informant's Name/Relationship (Type, Print): Katrina Patrice Thompson
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 2710 Lauretta Avenue, Balt. MD 2123

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of camatery, cremetory or other piece):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licansee: Joseph B. Van Sant
22. Name and Address of Feclity: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth): e. Extreme Prematurity

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopay performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Piece of Deeth (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year):
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred:
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify):
28f. Location (Street end Number or Rural Route Number, City or Town, Stete):

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end piece, and due to the cause(s) end menner ss steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) end manner stated.

29b. Signeture and title of certifier: ▶ Lawyer
29c. Licanse number: D0051900
29d. Dete signed (Month, Day, Year): may 8, 1998

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): L Lawyer 301 St. Paul Place Balt. MD 21202

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 26 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16249

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Shay
2. Date of Death Month/Day/Year: May 23 1998
3. Time of Death: 2100
4a. Facility Name (If not institution, give street and number): Howard County Gen. Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 220-80-9934
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 18, 1919
9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Upperco
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 15520 Hanover Road
10f. Zip Code: 21155
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Homemaker

17. Father's Name (First, Middle, Last): Boyd W. Clubb
18. Mother's Name (First, Middle, Maiden Surname): Ethel Fay Clubb

19a. Informant's Name/Relationship (Type, Print): Harry L. Shay
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15520 Hanover Rd., Upperco, Md. 21155

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Evergreen Mem. Gardens
Date: May 28, 1998
20c. Location - City or Town, State: Finksburg, Md.

21. Signature of Funeral Service Licensee: ▶ H.H. Eckhardt
22. Name and Address of Facility: Eckhardt Funeral Chapel, 11605 Reisterstown Rd., Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Sepsis — 4 days
Due to (or as a consequence of):
b. Chronic Obstructive Pulmonary Disease — 5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ M.D.
29c. License number: 005778
29d. Date signed (Month, Day, Year): May 24, 1998
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 11055 Little Patuxent Pkwy Ste 205 Columbia MD 21045

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998
32. Registrar's Signature: ▶ Gina Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

98-2863-013
B.K.S
CAROL ESTHEL SIMONS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16250

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Carol Esthel Simons	MAY 19, 1998	1755 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4310 SYCAMORE DRIVE	HAMPSTEAD	CARROLL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-48-7012	1☐ M 2☒ F	51 Yrs.					Sept. 21, 1946	Md.

Usual Residance of Dacedant

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	Carroll	Hampstead	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4310 Sycamore Drive	21074	U.S.A.

11. Marital Status	12. Was Dacedent Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.)	14. Race - American Indian, Black, White, atc.
1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:	1☐ Yas 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highast grada complatad)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Housewife	Own Home

17. Fathar's Nama (First, Middle, Last)	18. Mothar's Nama (First, Middle, Maidan Surnama)
Edgar A. Poe	Bertha Williams

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code)
Edward M. Simons Husband	4310 Sycamore Drive Hampstead, Md. 21074

20a. Mathod of Disposition	20b. Place of Disposition (Nama of cematary, cramatory or othar place)	Data	20c. Location - City or Town, Stata
1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)	Carroll Cremation	5/22/98	Hampstead, Md

21. Signature of Funaral Sarvica Licansaa	22. Nama and Addrass of Facility
[signature]	11824 Reisterstown Rd. Eline Funeral Home Reisterstown, Md. 21136

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

		Approximate Interval Between Onsat and Death
Immediate Causa (Final disaasa or condition rasulting in daath)	e. Contact Gunshot Wound of Chest	
	Due to (or as a consequanca of):	
Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Ceuse (Diseese or Injury that initiated avants rasulting in death) Last	b.	
	Dua to (or es e consequence of):	
	c.	
	Dua to (or as a consaquance of):	
	d.	

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Ware autopsy findings available prior to completion of cause of death?
1☒ Yas 2☐ No	1☒ Yas 2☐ No

25. Was casa rafarrad to medical examinar?	26. Place of Death (Check only ona)
1☒ Yas 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Othar: 4☐ Nursing Homa 5☒ Rasidanca 6☐ Othar (Specify)

27. Mennar of Daath	28a. Data of Injury (Month, Day, Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Naturel 2☐ Accident 3☒ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be determined	5/19/98	1755 M	1☐ Yas 2☒ No	Subject shot self

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify): At Home

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata): 4310 Sycamore Dr. 21074

29a. Cartifiar (Check ona): 1☐ **Cartifying Phyaician**: To the best of my knowledge, daath occurred at tha tima, data and placa, and dua to the ceuse(s) and manner as stated. 2☒ **Medical Examinar**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and dua to tha causa(s) and mannar statad.

29b. Signature and title of certifiar	29c. Licansa number	29d. Data signed (Month, Day, Yaar)
[signature] MD	O.C.M.E	MAY 20, 1998

30. Nama and addrass of person who completed causa of death (Itam 23a) (Typa, Print)
J. LaFon Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filad (Month, Day, Yaar)	32. Registrar's Signatura
MAY 26 1998	[signature]

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16251

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Sanders
2. Date of Death (Month, Day, Year): May 24 1998
3. Time of Death: 1300
4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 067-14-5451
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 20, 1920
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Jessup
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7716 Sharewood Drive
10f. Zip Code: 20794
10g. Citizen of What Country?: Howard

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Harry Moyer
18. Mother's Name (First, Middle, Maiden Surname): Anna Pollack

19a. Informant's Name/Relationship (Type, Print): Bob Stubblefield - Son-in-law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7716 Sharewood Drive, Jessup, MD 20794

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lakemont Memorial Gardens
Date: 05/28
20c. Location - City or Town, State: Davidsonville, MD

21. Signature of Funeral Service Licensee: Patrick J. Hardesty
22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Chronic Obstructive Pulmonary Disease 5 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature], M.D
29c. License number: D05728
29d. Date signed (Month, Day, Year): May 24 1998
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 11055 Little Patuxent Pkwy Ste 205 Columbia, MD 21045

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16252

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HELEN SCOTLAND

2. Date of Death Month: May Day: 15 Year: 1998

3. Time of Death: 5 PM

4a. Facility Name *(If not institution, give street and number)*: Rock Glen Nursing Center

4b. City, Town, or Location of Death: BALTIMORE Md.

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 129 18 1940

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 (Yrs.)

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 2.20.13

9. Birthplace *(State or Foreign Country)*: ALTOONA, PA.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 10 Rockland Road

10f. Zip Code: 21229

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Stenographer

16b. Kind of Business/Industry: unknown

17. Father's Name *(First, Middle, Last)*: James Adams Scotland

18. Mother's Name *(First, Middle, Maiden Surname)*: Marie Estella Scotland

19a. Informent's Name/Relationship *(Type, Print)*: Rachel Scotland/sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 229 Northmont Avenue, Baltimore, Maryland 21216

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Joseph B. Van Sant — Boyd B. Van Sant

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardio Vasular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

1yr Above Knee amputation (L) leg

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: DS Saluja MD

29c. License number: D 17537

29d. Date signed *(Month, Day, Year)*: 5.19.98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR DARSHAN S. SALUJA MD 1600 W. MOUNT Royal Ave, Balto 21217

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998

32. Registrar's Signature: Gilda Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16253

Certificate of Death

Reg. No.

Physician /Medical Examiner | **Funeral Director**

1. Decedent's Name (First, Middle, Last): Mollie F. Shavell
2. Date of Death: Month May Day 19 Year 1998
3. Time of Death: 1130 AM
4a. Facility Name (If not institution, give street and number): Mayford Manor Nursing Home
4b. City, Town, or Location of Death: Pikesville
4c. County of Death: Baltimore
5. Social Security Number: 215-05-2158
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7-1-11
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: FLORIDA
10b. County: BROWARD
10c. City, Town or Location: COCONUT CREEK
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3202 PORTOFINO POINT, APT. A-3
10f. Zip Code: 33066
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12) / College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TREASURER
16b. Kind of Business/Industry: TAVERN/RESTAURANT

17. Father's Name (First, Middle, Last): HARRY FINE
18. Mother's Name (First, Middle, Maiden Surname): ANNIE GORDON

19a. Informant's Name/Relationship (Type, Print): SOLOMON SHAVELL (HUS.)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3202 PORTOFINO POINT, APT. A-3 COCONUT CREEK, FL 33066

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BETH EL MEMORIAL PARK
Date: 5/21/98
20c. Location - City or Town, State: RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: Michael Kruger
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cerebral infarction	6 Months
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	Pneumonia	2 weeks
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ira H Copeland MD
29c. License number: D 27034
29d. Date signed (Month, Day, Year): May 19 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ira H Copeland MD 5310 Old Court Rd Randallstown MD 21133

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit slips.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16254

Certificate of Death

Reg. No.

Senker, Samuel

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Samuel Senker

2. Date of Death (Month, Day, Year): MAY 22 1998

3. Time of Death: 2:30 PM

4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-16-4692

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 5,1920

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [ ] No XXX

10e. Street and Number: 6606 Park Heights Ave Apt 414

10f. Zip Code: 21215

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [XX] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [XX] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mobile Dog Grooming

16b. Kind of Business/Industry: Dog Grooming

17. Father's Name (First, Middle, Last): Sylvan Senker

18. Mother's Name (First, Middle, Maiden Surname): Edith Pachholder

19a. Informent's Name/Relationship (Type, Print): Mrs Ruth Senker (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6606 Park Heights Ave Apt 414, Baltimore, MD 21215

20a. Method of Disposition: 1 [XX] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hebrew Friendship

Date: 5/24/98

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Scott M. Cutler

22. Name and Address of Facility: Sol Levinson & Bros 8900 Reisterstown Rd, Pikesville, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrest — 2m

Due to (or as e consequence of):

b. Severe Myocardial Infarction — 36h

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Coronary & Valvular Heart disease + renal failure

Due to (or as a consequence of):

d. Diabetes & Sarcoma

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Sarcoma non-Hodgkin's

Coronary

S/P leg bypass Surgery.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D40121 MD.

29d. Date signed (Month, Day, Year): 5/23/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dale Buchbinder Greater Baltimore Medical Center Towson, MD

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

10

DHMH 16 Rev 6/95

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16255

Certificate of Death

Reg. No.

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
PHILIP JAMES	SIEJACK JR.		May 21, 1998	1:30p
4e. Facility Name (If not Institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death		
The Johns Hopkins Hospital	Baltimore	NA		

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-36-8976	X 1☐M 2☐F	57 Yrs.			Jan. 26 41	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	NA	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
720 Souyh Lakewood Avenue	21224	U.S. of America

11. Marital Stetus	12. Was Decedent Evar in U,S. Armed Forces?	13. Wes Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puarto Rican, etc.)	14. Rece - American Indien, Black, Whita, etc.
1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yas, Give Yeer or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grede completed)		16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
10	NA	Driver	Taxicab

17. Fether's Nama (First, Middle, Last)		18. Mother's Nema (First, Middle, Maiden Surname)	
Philip	Siejack	Bertha	Siminski

19a. Informant's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
Diana Siejack (Wife)	702 South Lakewood Ave. Balto., Md. 21224

20e. Method of Disposition	20b. Piece of Disposition (Name of cemetery, cremetory or othar place)	Date	20c. Locetion - City or Town, Stete
1☐ Burial 2☒ Cramation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)	Metro	May 26	Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Mark A. Skonieczki

22. Nama end Address of Facility: W. Dabrowski-Chojnacki F.H.'s P.A. 1005 Dundalk Ave. Balto., Md. 21224

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Ceuse (Finel diseese or condition resulting in deeth)	a. MYOCARDIAL INFARCTION	24 hours
	Due to (or es e consequence of):	
Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest	b. AORTIC STENOSIS	
	Due to (or es e consequence of):	
	c.	
	Dua fo (or as a consequance of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner stated.

29b. Signetura and fitle of certifier	29c. Licensa number	29d. Dete signed (Month, Day, Year)
▶ H.M. Wickramasinghe, M.D.	RES 000	May21, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): H.M. WICKRAMASINGHE, M.D. JOHNS HOPKINS HOSPITAL, BALTIMORE

State Registrar

31. Dete filed (Month, Day, Year): MAY 26 1998

32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 98 16256

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Taylor
2. Data of Death Month Day Year: May 23, 1998
3. Time of Death: 355 pm
4a Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-40-7191
6. Sex: 1☐ M 2☐ F — X
7. Aga (In yrs. last birthday): 59 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): JAN 15, 1939
9. Birthpleca (State or Foraign Country): Maryland

Usual Residence of Dacedant

10a. Stete: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 4017 Liberty Heights Ave.
10f. Zip Coda: 21207
10g. Citizan of What Country?: USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Educetion (Specify only highest grade completed)
Elemantary/Secondery (0-12): 12
College (1-4or 5+):
16e. Dacedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Brick Mason
16b. Kind of Business/Industry: Masonry

17. Fether's Nama (First, Middle, Last): Hugh W. Taylor
18. Mother's Nama (First, Middle, Meiden Surnama): Estelle Emily Anderson

19a. Informent's Name/Ralationship (Type, Print): Ruth T. Wilson/sister
19b. Mailing Address (Streat and Number or Rurel Route Number, City or Town, Stete, Zip Code): 3811 Callaway Ave. Baltimore, MD 21215

20e. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramovel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece): Metro Crematory, Inc.
Dete: 5/26/98
20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funerel Service Licensee: Edward A. Gregorchik
Edward A. Gregorchik
22. Name end Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heert feilure. List only ona causa on aech line.

Approximate Interval Batwaen Onset and Death

Immediete Ceuse (Finel disease or condition resulting in daath)
e. Sepsis — 48 hrs
Due to (or es a consequence of):
b. Stroke — 24 hrs
Sequentially list conditions, if any, leeding to immediate cause. Entar Underlying Cause (Diseese or Injury thet initiated events resulting in death) Last
Due to (or as a consaquence of):
c.
Dua to (or as a consaquence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Ware autopsy findings available prior to completion of causa of death? 1☐ Yas 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Placa of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Mannar of Deeth: 1☒ Naturel 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Straet and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurrad at the time, data end plece, end due to the ceuse(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Harshi Bains MD/PhD
29c. License number: AS2402321 HBA9517
29d. Data signed (Month, Day, Year): May 23, 1998

30. Neme end eddress of person who completed ceuse of death (Item 23a) (Type, Print): HARSHI BAINS Sinai HOSP OF BALTIMORE.

State Registrar

31. Dete filed (Month, Dey, Year): MAY 26 1998
32. Registrer's Signeture: Julie Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit.

Division of Vital Records, P.O. Box 68760,

4

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16257

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Genevieve Eleanor Turner

2. Dete of Deeth: Month May Day 23, Yeer 1998

3. Time of Death: 10:45 am

4e. Feciility Neme *(If not institution, give street and number)*: Future Care - Cherrywood

4b. City, Town, or Location of Death: Reisterstown

4c. County of Deeth: Baltimore

Funeral Director

5. Sociel Security Number: 215-09-8404

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Yeer)*: Nov. 9, 1916

9. Birthplece *(Stete or Foreign Country)*: Maryland

Usuel Residenca of Decedent

10a. Stete: Md.

10b. County: Baltimore

10c. City, Town or Location: Owings Mills

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 19 E Phlox Circle

10f. Zip Code: 21117

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 | College (1-4or 5+): 3

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Homemaker

17. Father's Name *(First, Middle, Last)*: Vernon Lee Sommers

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Genevieve Watts

19e. Informent's Neme/Reletionship *(Type, Print)*: Lynn Greenwalt

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 603 Brunk Ct., Reisterstown, Md. 21136

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Lorraine Park Cemetery

Date: May 26,1998

20c. Location - City or Town, Stete: Woodlawn, Md.

21. Signeture of Funerel Servica Licensee: H. J. Eckhardt

22. Neme end Address of Feciliity: Eckhardt Funeral Chapel, 11605 Reisterstown Rd., Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Intervel Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. Acute Respiratory Failure

Due to (or es e consequence of): b. Sepsis

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last: Due to (or as e consequenca of): c. Pneumonia

Due to (or as e consequenca of): d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Hypertensive Heart Disease; Right Sided Embolic CVA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Wes an eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings availeble prior to completion of ceuse of deeth? 1☐ Yes 2☑ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Day Yeer)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner**: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: Miguel Sadovnik

29c. License number: D40867

29d. Date signed *(Month, Day, Yeer)*: 5/26/98

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): MIGUEL SADOVNIK, 1833 GREEN TREE Rd. BALT, MD 21208

State Registrar

31. Dete filed *(Month, Day, Yeer)*: MAY 26 1998

32. Registrar's Signature: Tisha Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that tha death certificate be executed within 24 hours eftar death.
To the Funeral Director: After this certificate has been signed by tha attending physician and completely filled in by tha funeral director, page 2 should be detached for usa as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

50

DHMH 16 Rev 6/95

Item#11,12,15,16a,16b,20a,20b,20c,21,22 per Inf G760 6/22/98 EW
Amend: #6 Per Anatomy Board Film G759 5-26-98RC

98 16258

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): George Garfield Tyson					2. DATE OF DEATH (Month, Day, Year): May 18 98		3. TIME OF DEATH: 6:15 a.m.
4. SOCIAL SECURITY NUMBER: 213-28-3142	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): ~~63~~ 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Dec. 15, 1924		8. BIRTHPLACE (State or Foreign Country): NorthCarolina
9a. FACILITY NAME (If not institution, give street and number): Golden Oaks Convalescent and Rehab Ctr.			9b. CITY, TOWN OR LOCATION OF DEATH: Laurel		9c. COUNTY OF DEATH: Prince George		

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George	10c. CITY, TOWN OR LOCATION: Laurel	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 9001 Cherry Lane		10f. ZIP CODE: 20708	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: ~~unknown~~ 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Nov 1943- Feb 1946	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ~~unknown~~ 11th; College (1-4 or 5+): ~~unknown~~	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ~~unknown~~ Cement Finisher	16b. KIND OF BUSINESS/INDUSTRY: ~~unknown~~ Construction	
17. FATHER'S NAME (First, Middle, Last): William Tyson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Tyson	
19a. INFORMANT'S NAME (Type/Print): Gregory George Tyson/son		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4125 Warner Avenue, Alanver Hills, Maryland 20784	

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) ~~in state~~	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Quantico National Cemetery	DATE: 5/27/98	20c. LOCATION — City or Town, State: Quantico Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ~~Joseph Bryan Sant~~ Robert A. Smith	22. NAME AND ADDRESS OF FACILITY: ~~State Anatomy Board, 655 W. Baltimore St. Baltimre, Maryland~~ 21201 Robert G. Mason Funeral Home ,Wash D.C.		

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	PROBABLE ACUTE MYOCARDIAL INFARCTION	ACUTE
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	CORONARY ARTERY DISEASE	YRS
DUE TO (OR AS A CONSEQUENCE OF):		
c.	ATHEROSCLEROSIS	YRS
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE
DIABETES MELITUS, PARANOID DEMENTIA

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D25422	29d. DATE SIGNED (Month, Day, Year): ▶MAY 18, 1998
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERT Y. MACLIN, MD 13952 BALTIMORE AVE, LAUREL, MARYLAND 20707		
31. DATE FILED (Month, Day, Year): MAY 26 1998	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-18 Rev 1/89

98-2883-510
B.K.S
DANTA LAMONT TAFT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16259

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donta Lamont Taft
2. Date of Death Month MAY Day 20, Year 1998
3. Time of Death: 1205 PM
4a. Facility Name (If not institution, give street and number): 28 SOUTH KOSSUTH STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-86-3751
6. Sex: 1 M 2 F
7. Age (In yrs. last birthday): 23 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 10-19-74
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 Yes 2 No
10e. Street and Number: 28 South Kossuth St.
10f. Zip Code: 21229
10g. Citizen of What Country? USA

11. Marital Status: 1 Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): laborer
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Earl Taft
18. Mother's Name (First, Middle, Maiden Surname): Debra Lawson

19a. Informant's Name/Relationship (Type, Print): Shannon Howard wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 28 S. Kossuth St. Balto. Md. 21229

20a. Method of Disposition: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cem.
Date: 5/27/98
20c. Location - City or Town, State: Lansdowne

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Gilbert P. Wylie Funeral Home PA 638 N. Gilmor St. 21217

Physician /Medical Examiner

22a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CONTACT GUNSHOT WOUND OF HEAD
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No
26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day Year): 5 20 98
28b. Time of Injury: 1200 A M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred: SUICIDE SHOT SELF.
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): RESIDENCE
28f. Location (Street and Number or Rural Route Number, City or Town, State): 28 S KOSSUTH ST BALTIMORE MD

29a. Certifier (Check only one): 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): MAY 21, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYANN K. KOREN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998
32. Registrar's Signature:

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

6

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16260

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGUERITE TUTCHTON
2. Date of Death: Month 05 Day 22 Year 98
3. Time of Death: 3:30PM
4a. Facility Name (If not institution, give street and number): MARINER HEALTH OF FOREST HILL
4b. City, Town, or Location of Death: FOREST HILL
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 214-22-6070
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 26, 1910
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 315 Magnolia Terrace
10f. Zip Code: 21221
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) 7th; College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own home

17. Father's Name (First, Middle, Last): Winfield Scott Hellman
18. Mother's Name (First, Middle, Maiden Surname): Lily DAy Boblitz

19a. Informant's Neme/Relationship (Type, Print): Judith Forno /daughter
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1317 Sorbus Court Fallston Md. 21047

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): OAkLawn Cemetery
Date: 5/27/98
20c. Location - City or Town, Stete: Balitmore Md.

21. Signature of Funeral Servica Licansee: ▶ R. Terry Comelly
22. Name and Address of Facility: Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications that causad the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary embolism — 1 day

Due to (or as a consequence of):
b. Coronary artery disease — >1 Year

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

Due to (or as a consequence of):
c.

Dua to (or as a consequence of):
d.

Part II. **Other significant conditione** contributing to death but not rasulting in the underlying cause given in Part I.
Hypertension

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was cesa referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not ba determined

28a. Data of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete end place, and dua to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D28339
29d. Date signed (Month, Dey, Yeer): May 24 1998

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): LINDA FACILICI 101 E Wheel Road Bel Air MD 21015

State Registrar

31. Date filed (Month, Dey, Year): MAY 26 1998
32. Registrar's Signature: Erika Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16261

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Abraham Vereide

2. Date of Death: Month MAY Day 21 Year 1998

3. Time of Death: 5 09 AM

4a. Facility Name *(If not institution, give street and number)*: 2662 Compass Drive

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 533-22-9622

8. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 16, 1929

9. Birthplace *(State or Foreign Country)*: Washington

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2662 Compass Drive

10f. Zip Code: 21401

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1951-53

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Claims Manager

16b. Kind of Business/Industry: Insurance

17. Father's Name *(First, Middle, Last)*: Abraham Vereide, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Mattie Hansen

19a. Informant's Name/Relationship *(Type, Print)*: Martha L. Vereide - Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2662 Compass Drive, Annapolis, MD 21401

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veterans Cemetery

Date: 05/26

20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: Barbara J. Cahill

22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MALIGNANT PARAGANGLIOMA — 3 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: E. Cole MD

29c. License number: D 16354

29d. Date signed *(Month, Day, Year)*: MAY 21, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): E. COLE 900 BESTGATE RD #300 ANNAPOLIS MD 21401

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16262

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDNA WEST

2. Data of Death — Month: MAY Day: 19 Yaar: 1998

3. Tima of Death: 10:21 PM

4a. Facility Name (If not institution, giva street and number): SINAI HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 219-14-2066

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Day, Year): 7 13 15

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1520 W. North Avenue Apt 204

10f. Zip Code: 21217

10g. Citizen of What Country? U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowad 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Educetion (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic Worker

16b. Kind of Business/Industry: Domestic Work

17. Father's Name (First, Middle, Last): Josha Brown

18. Mother's Name (First, Middle, Meiden Sumame): Hester Howard

19a. Informant's Name/Reiationship (Type, Print): Milton Brown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1723 McKean Avenue Baltimore, Maryland

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Baltimore National

Date: 5-27-98

20c. Location - City or Town, Stata: Baltimore Maryland

21. Signature of Funeral Service Licensee: Irvin P. Carroll

22. Nama and Address of Facility: Irvin P. Carroll Funeral Home 1712 W. North Avenue Baltimore Maryland

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Finei disease or condition resulting in death)

a. LACTIC ACIDOSIS — ONE DAY

Due to (or as a consequence of):

b. SEPSIS — ONE DAY

Sequantiaily iist conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

Due to (or as a consequence of):

c. PNEUMONIA — ONE DAY

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☑ No

25. Was case referred to medical examinar? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Girish V. Nair, M.D.

29c. License number: AS240232IGN-9456

29d. Date signad (Month, Day, Year): MAY 19, 1998

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): GIRISH, V. NAIR, M.D. 2401 WEST BELVEDERE AVENUE BALTIMORE, MARYLAND 21215

State Registrar

31. Date filed (Month, Day, Year): MAY 26 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: Tha law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificata has been signed by tha attending physician and completaly filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Pages 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

98-2884-510
BKS
MARIAN WHITE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16263

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): MERION LABELLE WHITE
2. Dete of Deeth — Month: MAY Day: 20 Year: 1998
3. Time of Death: 10:28 AM
4a. Facility Neme (If not institution, give street end number): 5210 FREDCREST ROAD
4b. City, Town, or Location of Deeth: BALTIMORE
4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 416-56-9424
8. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthdey): 56 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): Sept. 10, 1941
9. Birthplece (Stete or Foreign Country): ALABAMA

Usuel Residence of Decedent

10a. Stete: OHIO
10b. County: N/A
10c. City, Town or Location: CLEVELAND
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 16807 STOCKBRIDGE AVE.
10f. Zip Code: 44128
10g. Citizen of Whet Country? U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Wes Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☑ No — If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12); College (1-4or 5+): 2yrs
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): NURSE
16b. Kind of Business/Industry: NURSING HOME

17. Fether's Neme (First, Middle, Last): CHARLIE HARVEY
18. Mother's Neme (First, Middle, Maiden Surneme): MARGARET L. DOUGLAS

19a. Informent's Neme/Relationship (Type, Print): JOYCE DIXON
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 5210 FREDCREST RD. BALT, MD. 21229

20a. Methods of Disposition: 1☑ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other place): HIGHLAND PARK — Dete: 5/22/98
20c. Location - City or Town, Stete: HIGHLAND HILL OHIO

21. Signeture of Funerel Service Licensee: [signature]
22. Neme end Address of Fecility: GARY F. MARCA FUNERAL HOME PA 270 FREDERICK PASS BALT, MD. 21229

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory erreet, shock, or heert failure. List only one ceuse on eech line. — Approximete Intervel Between Onset end Deeth

Immediete Cause (Finel disease or condition resulting in deeth): a. HEPATOCHOLANGIOCARCINOMA
Due to (or es e consequence of):
Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest:
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying ceuse given in Pert I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? INSPECTION 1☐ Yes 2☒ No
24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? ☒ Yes 2☐ No
26. Place of Deeth (Check only one) — Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) AT SCENE

27. Menner of Deeth: ☒ 1 Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated. ☒ **Medical Examiner:** On the bests of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end ptece, and due to the cause(s) end menner stated.
29b. Signeture end title of certifier: [signature]
29c. License number: O.C.M.E
29d. Dete signed (Month, Dey, Yeer): MAY 20, 1998
30. Neme end Address of person who completed ceuse of deeth (Item 23e) (Type, Print): J. LARON LOCKE, MD — J. Laron Locke M.D. 111 PENN STREET, BALTIMORE, MARYLAND 21201

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 26 1998
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16264

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Hattie Mae White
2. Date of Deeth — Month: MAY; Dey: 22; Year: 1998
3. Time of Death: 1:30 P.m
4a. Facility Neme *(If not institution, give street and number)*: Maryland General Hospital
4b. City, Town, or Location of Deeth: Baltimore City
4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 577-24-5638
6. Sex: 1☐ M 2☑ F
7. Age *(In yrs. last birthday)*: 82 Yrs.
If Under 1 Year — Months: ; Days:
If Under 24 Hrs. — Hours: ; Min.:
8. Date of Birth *(Month, Day, Year)*: 1-22-1916
9. Birthplace *(State or Foreign Country)*: North Carolina

Usuel Residence of Decedent

10e. Stete: Md
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street end Number: 1564 Moreland Ave
10f. Zip Code: 21216
10g. Citizen of Whet Country?: USA
11. Maritel Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☑ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify*: Black
15. Decedent's Educetion *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Custodian
16b. Kind of Business/Industry: Dept. of Education
17. Father's Name *(First, Middle, Last)*: Clarence Round Tree
18. Mother's Name *(First, Middle, Maiden Surname)*: Nicy Carr
19e. Informent's Neme/Relationship *(Type, Print)*: Mr. Andrew White (Husband)
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1564 Moreland Ave. Balto. Md. 21216
20e. Method of Disposition: 1☑ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland National Cem. Date: 5/28/98
20c. Location - City or Town, State: Laurel, Maryland
21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave, Baltimore, Maryland 21216

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Final disease or condition resulting in deeth)
e. End Stage Lymphoma
Due to (or es e consequence of):
Sepsis — 3 Days

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Lest
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Nelurel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, date and piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Exeminer:** On the besis of exeminetion end/or Investigetion, in my opinion, death occurred et the time, dete end piece, end due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier: Amatun M. Naeem
29c. License number: D 15503
29d. Date signed *(Month, Day, Year)*: May 23, 1998

30. Name end eddress of person who completed ceuse of deeth *(Item 23e)* (Type, Print): Dr. Amatun Naeem 40 Maryland General Hospital

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 26 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: Tha law requires that tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by tha attending physician and completely filled in by the funeral director, page 2 should be detached for use as tha burial-transit permit.

White, Hattie

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16265

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
ADA	WENDELL	MAY	20	1998	10:35 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
7121 PARK HEIGHTS AVE., APT. 307	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-66-6952	1☐ M 2☒ F	91 Yrs.					NOV.29,1906	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7121 PARK HEIGHTS AVE., APT. 307	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOUSEWIFE	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
DAVID SCHAPIRO	ANNIE GOLDBERG

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ROBERT WENDELL (SON)	62 RIVER OAKS CIR., BALTIMORE, MD 21208

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	HAR SINAI	5/22/98	OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: Burton H. Levinson

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	2 DAYS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐ Yes 2☒ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Eric Fisher MD	D25331	5/21/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 101 W. READ ST. BALTIMORE, ERIC FISHER MD. 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 26 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16266

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Lola Frances WOLINSKI
2. Date of Death Month Day Year: May 15, 1998
3. Time of Death: 10:30 AM
4a. Facility Name (If not institution, give street and number): 118 Sandy Hook Road
4b. City, Town, or Location of Death: Berlin
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 242-48-4601
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08/15/1935
9. Birthplace (State or Foreign Country): Tennessee

Usual Residence of Decedent

10a. State: Maryland
10b. County: Worcester
10c. City, Town pr Location: Berlin
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 118 Sandy Hook Road
10f. Zip Code: 21811
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 1 Year
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Business Owner
16b. Kind of Business/Industry: Construction

17. Father's Neme (First, Middle, Last): Leroy Thompson
18. Mother's Name (First, Middle, Maiden Surname): Lillian Russel

19a. Informant's Name/Relationship (Type, Print): Ted Wolinski / Spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 118 Sandyhook Rd. Ocean Pines, Maryland 21811

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Pleca of Disposition (Name of cametery, crematory or other place): Sacred Heart of Jesus | Date: 5/20/98
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Kathleen Weber CFSP
22. Name and Address of Facility: David J. Weber Funeral Home 401 S. Chester Street Baltimore, Maryland 21231

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Renal Failure
Due to (or as a consequenca of):
b. Pelvic Sarcoma
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residenca 8☐ Other (Specify)

27. Manner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dale and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Douglas Bruce
29c. License number: D31974
29d. Dale signed (Month, Day, Year): 5/18/98
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Douglas Bruce MD 314 Franklin Ave, Berlin, Md 410-641-2696

State Registrar

31. Dete filed (Month, Day, Year): MAY 26 1998
32. Registrar's Signature: Linda Parker-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 16267

Reg. No.

AKA: DANIEL W. WARNER

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DANIEL WEBSTER WARNER

2. Date of Death: Month: May; Day: 22; Year: 1998

3. Time of Death: 1:20 AM

4a. Facility Name *(If not institution, give street and number)*: VAMC FORT HOWARD DIVISION

4b. City, Town, or Location of Death: Ft.Howard

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-16-6678

6. Sex: 1☐ M 2☐ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months; Days

If Under 24 Hrs.: Hours; Min.

8. Date of Birth *(Month, Day, Year)*: July 6,1924

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3342 East Baltimore Street

10f. Zip Code: 21224

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machinest

16b. Kind of Business/Industry: Beth Steel

17. Father's Name *(First, Middle, Last)*: John Leo Warner

18. Mother's Name *(First, Middle, Maiden Surname)*: Catherine Tyler

19a. Informant's Name/Relationship *(Type, Print)*: Evelyn Warner /wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3342 East Baltimore Street Balto.Md.21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: BelAirMemorial

Date: 5/26/98

20c. Location - City or Town, State: BelAir Md.

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Small Cell Lung Cancer — UNKNOWN

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Marcos Galicia MD

29c. License number: D15698

29d. Date signed *(Month, Day, Year)*: May 22, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marcos Galicia, MD 9600 North Point Road Fort Howard, MD 21052

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998

32. Registrar's Signature: ▶ Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

8

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16268

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WAYNE P.M. YARBOROUGH SR.

2. Date of Death — Month: May; Day: 15; Year: 1998

3. Time of Death: 7:45 PM

4a. Facility Name *(If not institution, give street and number)*: Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-28-5040

6. Sex: 1 ☑ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 58 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: AUG. 14, 1939

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: MD.

10b. County: BALTIMORE

10c. City, Town or Location: PIKESVILLE

10d. Inside City Limits: 1 ☐ Yes 2 ☑ No

10e. Street and Number: 8205 ARROWHEAD RD.

10f. Zip Code: 21208

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?: 1 ☐ Yes 2 ☑ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☑ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12TH; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CHEMICAL TECHNICIAN

16b. Kind of Business/Industry: PAINT

17. Father's Name *(First, Middle, Last)*: ISIAH YARBOROUGH

18. Mother's Name *(First, Middle, Maiden Surname)*: CLARA HILL

19a. Informant's Name/Relationship *(Type, Print)*: MILDRED YARBOROUGH

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8205 ARROWHEAD RD. PIKESVILLE MD. 21208

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: WOODLAWN CEM. — Date: 5/21/98

20c. Location - City or Town, State: WOODLAWN MD.

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: GARY F. MARCH FUNERAL HOME P.A. 270 FREDERICK

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Sepsis

Due to (or as a consequence of):
b. Infected Arteriovenous Fistula left Thigh

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atherosclerotic Cardiovascular Disease

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D17005

29d. Date signed *(Month, Day, Year)*: May 15, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gopal Guruswamy, M.D. c/o Maryland General Hospital

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 26 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Wayne Yarborough
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

4

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16269

Item 18 Per FH Film G759 5-26-98 rja

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
DR. HAROLD E.C. ZHEUTLIN	MAY 18, 1998	8:50 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
32 CAVESWOOD LANE	OWINGS MILLS	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
154-22-7414	1[X] M 2[ ] F	80 Yrs.			MAR. 25, 1918	NEW JERSEY

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	OWINGS MILLS	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
32 CAVESWOOD LANE	21117	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced	1[X] Yes 2[ ] No If Yes, Give Year or Dates:	1[ ] Yes 2[X] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	PHYSICIAN	MEDICAL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
NATHAN ZHEUTLIN	GOLDIE SWID ~~SWIB~~

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PHYLLIS ZHEUTLIN (WIFE)	32 CAVESWOOD LANE OWINGS MILLS, MD 21117

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	HAR SINAI	5/21/98	OWINGS MILLS, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Ellenore Levinson Jeffers	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. HEPATOCELLULAR CARCINOMA	5 MONTHS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[X] No 3[ ] Probably 4[ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[X] No	1[ ] Yes 2[X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1[ ] Yes 2[X] No	Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA	Other: 4[ ] Nursing Home 5[X] Residence 6[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D29373	5/19/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ERIC J. SEIFTER, MD 10755 FALLS RD, SUITE 200 LUTHERVILLE, MD 21093

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 26 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16270

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: IDA AI Binder
2. Dete of Deeth — Month: May; Day: 09; Yaar: 1998
3. Time of Deeth: 1640Pm
4e. Fecility Neme *(If not institution, give streat end number)*: SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Sacurity Number: 217.27.0452
6. Sax: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Yaar: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: 03.20.1922
9. Birthpleca *(Stata or Foreign Country)*: RUSSIA

Usuel Residence of Decedent

10e. Stete: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: GAITHERSBURG
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 17021 KING JAMES WAY, #202
10f. Zip Code: 20877
10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yas, Giva Yaar or Detes:
13. Was Decedenl of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Educelion *(Spacify only highest greda complated)*: Elementery/Secondary (0-12); College (1-4or 5+): 4
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: DEPARTMENT HEAD
16b. Kind of Business/Industry: GOVERNMENT

17. Fathar's Neme *(First, Middle, Last)*: MICHAEL SLAVIN
18. Mother's Neme *(First, Middla, Meiden Surnema)*: FAGA (UNOBTAINABLE)

19e. Informant's Neme/Relationship *(Type, Print)*: TONY AIBINDER/SON
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Steta, Zip Code)*: 107 LEAFCUP CT, GAITHERSBURG, MARYLAND 20878

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other pleca)*: JUDEAN MEMORIAL GARDENS
Dete: 5/11/98
20c. Location - City or Town, Stete: OLNEY, MARYLAND

21. Signature of Funeral Service Licensee ▶
22. Nama and Address of Fecility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only ona ceuse on aech line.

		Approximate Intervel Between Onset end Deeth
Immediela Cause (Finel diseese or condition resulting in deeth) e.	pericardial tamponade	3 days
Due to (or es a consequence of):		
Sequenlielly ilsl conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest — b.	myocardial rupture	3 days
Due to (or es e consequenca of):		
c.	myocardial infarction	1 week
Due to (or es e consequenca of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: metastatic breast cancer

23b. Did tobacco use contributa to the ceuse of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes an eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings avelleble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No
26. Plece of Deeth *(Check only one)*: Hospitel: 1☒ Inpalient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Rasidance 6☐ Other *(Specify)*
27. Mennar of Deeth: 1☐ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Dete of Injury *(Month, Day Year)*
28b. Time of injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end pleca, and due to the ceusa(s) end menner steted.

29b. Signeture end title of certifier ▶
29c. Licanse number: D43083
29d. Dete signed *(Month, Dey, Year)*: May 9, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): 9707 Medical Center Drive, #300 Rockville, MD 20850

State Registrar

31. Dete filed *(Month, Dey, Year)*: MAY 11 1998
32. Registrer's Signeture: Julia Davidson-Randell

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16271

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Pauline Isabel ARVIN

2. Date of Death — Month: May; Day: 12; Year: 1998

3. Time of Death: 2010

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-09-4364

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: Feb. 3 1912

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 11 W. Baltimore Street Apt. 208

10f. Zip Code: 21740

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementery/Secondery (0-12): 8; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Knitter

16b. Kind of Business/Industry: Knitting Factory

17. Father's Name *(First, Middle, Last)*: Christian Sellers

18. Mother's Name *(First, Middle, Maiden Surname)*: Dessie M. Chaney

19a. Informent's Name/Reletionship *(Type, Print)*: Edgar N. Arvin - Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11 W. Baltimore St. Apt. 208 Hagerstown, Md. 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rest Haven Cemetery

Date: 5/15/98

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott M Minnich

22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. congestive Heart failure — History

Due to (or as a consequence of):

b. Senile Cotting Acty Bros

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M Ward MD

29c. License number: 16602

29d. Date signed *(Month, Day, Year)*: 5-12-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): E. R. Landis MD 382 Frederick Boonsboro, Hagerstown, Md 21740

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 14 1998

32. Registrar's Signature: Julie Davidson-Randall

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Arvin, Pauline

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #19B, 5/19/98, CWC, Kent Co.

Certificate of Death

Reg. No. 98 16272

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bessie M. Blanchard
2. Date of Death Month Day Year: May 8, 1998
3. Time of Death: 10:30 p.m.
4a. Facility Name (If not Institution, give street and number): Kittys Domicillary Home
4b. City, Town, or Location of Death: Sudlersville
4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 366-26-4701
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): December 17, 1909
9. Birthplace (State or Foreign Country): Greenup, Il

Usual Residence of Decedent

10a. State: Maryland
10b. County:
10c. City, Town or Location: Chestertown
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 209 Creston Road
10f. Zip Code: 21620
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondary (0-12): 12
College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Herman A. Bruns
18. Mother's Name (First, Middle, Maiden Surname): Anna Lubbers

19a. Informant's Name/Relationship (Type, Print): William P. Blanchard/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 209 Creston Road ~~Po Box 353~~ Chestertown, Maryland 21620

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crumpton Cemetery/May 13, 1998
Date:
20c. Location - City or Town, State: Crumpton, MD

21. Signature of Funeral Service Licensee: ▶ Thomas K. Helfenbein
22. Name and Address of Facility: Fellows, Helfenbein, & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CardioRespiratory Arrest — 1 week

Due to (or as a consequence of):
b. ASCVD & CVA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Alzheimers Dementia, CHF, Afib, Hx Pacemaker. HTN, Hypothyroid.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D 50996
29d. Date signed (Month, Day, Year): 5/11/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 100 Brown St. Chestertown MD 21620

State Registrar

31. Date filed (Month, Day, Year): MAY 13 '98
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16273

Certificate of Death

Reg. No.

Oliver Briscoe

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): OLIVIER EDWARD BRISCOE
2. Date of Death: Month May Day 10 Year 1998
3. Time of Death: 2:44PM
4a. Facility Name (If not institution, give street and number): The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 217-14-8670
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02-01-25
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: KENT
10c. City, Town or Location: CHESTERTOWN
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 9075 FAIRLEE RD
10f. Zip Code: 21620
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WW2
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4 YRS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MATERIAL ENGINEER
16b. Kind of Business/Industry: STATE HIGHWAY

17. Father's Name (First, Middle, Last): OLIVIER BRISCOE
18. Mother's Name (First, Middle, Maiden Surname): ELSIE HAMILTON

19a. Informant's Name/Relationship (Type, Print): MRS SOLSTINE BRISCOE. WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9075 FAIRLEE RD · CHESTERTOWN, MD 21620

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CEM. EMMANUEL U.M. CHURCH | Date: 05-16-98
20c. Location - City or Town, State: CHESTERTOWN, MD

21. Signature of Funeral Service Licensee: ▶ Joyce O. Walley
22. Name and Address of Facility: WALLEY FUNERAL HOME 207 CALVERT ST. CHESTERTOWN, MD 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. small cell cancer with metastasis to liver	2 weeks
Due to (or as a consequence of):	b. chronic renal failure dialysis dependent -	years.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. athero sclerotic heart disease - Sepsis (8 years)	2 wks
Due to (or as a consequence of):	d. II Diabetes mellitus	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Prostate cancer with metastasis.
anemia of chronic disease.
Recent sigmoid colectomy for perforated diverticulites

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Medical Certification: To Be Completed by Physician/Medical Examiner

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ SYAP
29c. License number: D 46020
29d. Date signed (Month, Day, Year): 5/11/98.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SYED I ALI M.D. · 506 IDLEWILD AVE · EASTON, MD. 21601

State Registrar

31. Date filed (Month, Day, Year): MAY 15 '98
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 16274

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AUDREY EDITH MINSTER BOZZELLI
2. Date of Death (Month, Day, Year): MAY 6, 1998
3. Time of Death: 10:22
4a. Facility Name (If not institution, give street and number): 1344 Sudlersville Road
4b. City, Town, or Location of Death: Church Hill
4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 173-22-7922
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 67 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 7, 1930
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MD
10b. County: QUEEN ANNE
10c. City, Town or Location: CHURCH HILL
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1344 SUDLERSVILLE ROAD
10f. Zip Code: 21623
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 9 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Neme (First, Middle, Last): Edward Bailey Minster
18. Mother's Name (First, Middle, Meiden Surneme): Anne K. Minster-Phillips

19a. Informent's Name/Relationship (Type, Print): Kathleen Williamson/Daughter
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 5005 Williamsburg Church Road, Hurlock, MD 21643

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other piece): St. Dennis Cemetery/May 9, 1998
Date
20c. Location - City or Town, State: Galena, Maryland

21. Signature of Funerel Service Licensee: [signature] M-00237
22. Neme end Address of Facility: Fellows, Helfenbein, & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in death): e. ADENOCARCINOMA, UNKNOWN Primary — 14 MO

Due to (or as a consequence of):

Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Lest:
b.
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveileble prior to completion of cause ol deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner ol Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and pleca, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: [signature]
29c. License number: D01225
29d. Date signed (Month, Dey, Yeer): 11 MAY 98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): STEPHEN P. CARNEY, M.D., 509 IDLEWILD AVENUE, EASTON, MD 21601

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 13 '98
32. Registrar's Signature: [signature] Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16275

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Jane Elizabeth Headlee Buttrill

2. Date of Deeth Month Dey Yeer: May 8, 1998

3. Time of Deeth: 6:59 a.m.

4e. Feclity Neme *(If not Institution, give street end number)*: Kent & Queen Anne's Hospital

4b. City, Town, or Locetion of Deeth: Chestertown

4c. County of Deeth: Kent

Funeral Director

5. Sociel Security Number: 214-44-9271

6. Sex 1☐ M 2☒ F

7. Age *(In yrs. lest birthday)*: 77 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: January 25, 1921

9. Birthplece *(State or Foreign Country)*: Teague, Texas

To Be Completed by Funeral Director

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Queen Anne's

10c. City, Town or Locetion: Sudlersville

10d. Inside City Limits 1☐ Yes 2☐ No

10e. Street end Number: 273 Baxter Road

10f. Zip Code: 21668

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Reca - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+): 6

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: School Teacher

16b. Kind of Business/Industry: Anne Arundel Public School

17. Fether's Neme *(First, Middle, Last)*: Horace H. Headlee

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Lillian Miller

19e. Informent's Neme/Reletionship *(Type, Print)*: W. Hearon Buttrill/Husband

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 273 Baxter Road, Sudlersville, MD 21668

20e. Method of Disposition 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Plece of Disposition *(Neme of cemetery, cremetory or other place)*: Sudlersville Cemetery

Dete: May 12, 1998

20c. Locetion - City or Town, Stete: Sudlersville, Maryland

21. Signeture of Funeral Service Licensee: Thomas K. Helfenbein

22. Neme end Address of Feclity: Fellows, Helfenbein, & Newnam Funeral Home P.A. 130 Speer Road, Chestertown, MD 21620

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one cause on eech line.

Approximete Interval Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in death)

e. PERICARDIAL TAMPONADE — < 1 minute

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest

b. RUPTURED THORACIC AORTIC ANEURYSM — < 10 minutes

Due to (or es e consequence of):

c. ATHEROSCLEROSIS — > 10 years

Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

HYPERTENSION

POLYMYALGIA RHEUMATICA

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1☒ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Locetion *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)* 1☒ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es steted. 2☐ **Medicel Exeminer:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: Don R. Nichols MD

29c. License number: D41587

29d. Dete signed *(Month, Dey, Yeer)*: 5/11/98

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar

31. Dete filed *(Month, Day, Yeer)*: MAY 13 '98

32. Registrer's Signeture: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after death.
To the Funeral Director: After this certificete has been signed by the ettending physician end completely filled in by the funeral director, pege 2 should be detached for use es the buriel-transit

10

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16276

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PEARL BUNNELL

2. Date of Death Month: MAY Day: 12 Year: 1998 (FOUND)

3. Time of Death: 05:00 PM

4a. Facility Name (If not institution, give street and number): 8106 REDVIEW DRIVE

4b. City, Town, or Location of Death: FORESTVILLE

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 223-09 6946

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 30, 1919

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Forestville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8106 Redview Drive

10f. Zip Code: 20747

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Manager

16b. Kind of Business/Industry: Dental Office

17. Father's Name (First, Middle, Last): James Russell Barker

18. Mother's Name (First, Middle, Maiden Surname): Erma Hampton

19a. Informant's Name/Relationship (Type, Print): William C. Bunnell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8106 Redview Drive, Forestville, Maryland 20747

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): May 20, 1998 Arlington National Cemetery

20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road Clinton, Maryland 20735

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] DME

29c. License number: D33954

29d. Date signed (Month, Day, Year): MAY 13, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MARIO F. GOLVE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State Registrar

31. Date filed (Month, Day, Year): MAY 15 1998

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16277

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George ARTHUR Bealefeld, SR.
2. Date of Death Month: MAY Day: 11 Year: 1998
3. Time of Death: 10:00Pm
4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE medical center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214 01 4732
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-31-1908
9. Birthplace (State or Foreign Country): BALTIMORE

Usual Residence of Decedent

10a. State: md.
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6033 Hollins Avenue
10f. Zip Code: 21210
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): mold maker
16b. Kind of Business/Industry: Glass maker

17. Father's Name (First, Middle, Last): Barney Bealefeld
18. Mother's Name (First, Middle, Maiden Surname): Mamie East

19a. Informant's Name/Relationship (Type, Print): George A. Bealefeld, JR. / son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13020 Heil Manor Drive Reisterstown md 21136

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cem.
Date: 5/14/98
20c. Location - City or Town, State: Baltimore, md.

21. Signature of Funeral Service Licensee: Jeffrey N. Zumbrun
22. Name and Address of Facility: JEFFREY N. Zumbrun F.H. 6058 Sykesville Road Adelphia md 21784

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. acute myocardial infarction — hrs.

Due to (or as a consequence of):
b. renal failure — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. ASCUD

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CUA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward P. Costlow MD
29c. License number: D19503
29d. Date signed (Month, Day, Year): 5-12-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): E.P. COSTLOW M.D. 10 GERARD AVE 214 TIMONIUM MD 21093

State Registrar

31. Date filed (Month, Day, Year): MAY 13 1998
32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16278

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
RUTH DELLA BOWMAN	MAY 11, 1998	12:30 PM.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1742 UNIONTOWN RD.	WESTMINSTER	CARROLL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-24-3190	1☐ M 2☒ F	93 Yrs.			MAY 23,1904	NORTH DAKOTA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	CARROLL	WESTMINSTER	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1742 UNIONTOWN RD.	21158	USA.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11	4	NURSE	HEALTH

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
PETER F. ORN	DELLA SHELLMAN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JAMES BOWMAN - SON	1804 UNIONTOWN RD.,WESTMINSTER, MD. 21158

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	MT. CARMEL CEMETERY	5/14/98	SUNSHINE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility FLETCHER FUNERAL HOME
254 E. MAIN ST., WESTMINSTER, MD. 21157

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a. Ventricular fibrillation	minutes
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Atherosclerotic Heart disease	17 years
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Recurrent aspiration pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Christopher Nagamma MD	D18200	5/12/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CHITRACHEDY NAGANNA MD 700 A poole Rd westminster MD 21157

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 13 1998	Julie Strudwick Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend #7, 5/11/98, BMW, Montg.Co.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 16279

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Esther Margaret Burke	May	6	1998	2:20 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Suburban Hospital	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
316-16-3701	1☐ M 2☒ F	~~75~~ 74 Yrs.			May 27, 1923	Indiana

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Bethesda	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5208 Locust Avenue	20814	U. S. A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4 or 5+)		
	4	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Dennis Mattingly	Emma Spaulding

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Michael L. Burke - Husband	5208 Locust Avenue Bethesda, MD 20814

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Gate of Heaven Cemetery	5/11/98	Silver Spring, Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility Joseph Gawler's Sons
5130 Wisc. Ave. N.W. Washington, D. C. 20016

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Cardiogenic Shock	24 Hours
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Ischemic Cardiomyopathy	2 Months
Due to (or as a consequence of):		
	c. Caronary Artery Disease	Years
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Thrombocytopenia

Leukopenia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D 20535	May 7, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Roger Stevenson, Jr. M. D. 6410 Rockledge Drive #200 Bethesda, MD 20817

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 11 1998	[signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Bmw Burke, Esther

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2:24 AM 5/6/98

12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16280

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
FLORENCE	V.	BALDADIAN	MAY	13,	1998	6:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SHADY GROVE ADVENTIST HOSPITAL	ROCKVILLE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. lest birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplace (Stete or Foreign Country)
197-03-4809	1☐ M 2☒ F	86 Yrs.					DEC. 17, 1911	PA.

Usuel Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD,	MONTGOMERY	ROCKVILLE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13702 FRANKFORT CT.	20853	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grede completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
11		HOUSEWIFE	AT HOME

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
CHARLES BAKER	MARGARET KAROGLANIAN

19a. Informant's Name/Relationship (Type, Print)	19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
DOLORES M. BALDADIAN/DAUGHTER	SAME AS ITEM #10

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☐ Burie! 2☒ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)	CHAMBERS CREMATORY	5/18/98	RIVERDALE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ W.W. Chambers MO0091	CHAMBERS FUNERAL HOMES,P.A., SILVER SPRING, MD. 20910

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

		Approximete Interval Between Onset and Deeth
Immediate Cause (Final disease or condition resulting in death)	a. CONGESTIVE HEART FAILURE	FEW HRS.
	Due to (or es e consequence of):	
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest	b.	
	Due to (or es e consequence of):	
	c.	
	Due to (or es a consequence of):	
	d.	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

ATRIAL FIBRILLATION

SEPSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was en eutopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes case referred to medicel exeminer?	26. Piece of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how Injury occurred
1☒ Nature! 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as steted.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end piece, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ G Gupta, MD	D46398	MAY 13, 1998

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)
G. GUPTA, M.D. 121 CONGRESSIONAL LA. #409, ROCKVILLE, MD. 20852

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
MAY 15 1998	▶ Julie Davidson-Randell

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16281

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James T. Bannon
2. Date of Death Month: May Day: 13 Year: 1998
3. Time of Death: 6:28 AM
4a. Facility Name *(If not institution, give street and number)*: Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 037-14-6108
6. Sex: XX M 2☐ F
7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July08,1927
9. Birthplace *(State or Foreign Country)*: Massachusetts

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐ Yes 2XX No
10e. Street and Number: 9000 Briarcroft Lane, #140
10f. Zip Code: 20708
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married XX Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Horse Trainer
16b. Kind of Business/Industry: Race track

17. Father's Name *(First, Middle, Last)*: John E. Bannon
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary F. Attridge

19a. Informant's Name/Relationship *(Type, Print)*: Judith Craemer (wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: same as #10

20a. Method of Disposition: 1☐ Burial 2XX Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Date: May14,1998
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Donald V. Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home,. P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiopulmonary arrest-	1-2 hrs.
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Congestive heart- failure	1 day.
	Due to (or as a consequence of):	
	c. Cardiomyopathy	1 mth.
	Due to (or as a consequence of):	
	d. Tachyarrythemia - possible	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Sepsis

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2X No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2X No

25. Was case referred to medical examiner? 1X Yes 2☐ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2X ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1X Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Reedapi
29c. License number: D24174
29d. Date signed *(Month, Day, Year)*: 5/14/1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): PADMAJA S UDAPI M.D. 7350 VanDusen Road Suite 380 Laurel MD 20707

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 15 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

WRC
98-2663-031
SANDRA
BARUCH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16282

Items: 23 part I,27 per MEO G-759 5/29/98 rel

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
SANDRA LYNN BARUCH	MAY 11, 1998	1:26 AM.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
16609 LEOPOLD TERR.	DERWOOD	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-62-7073	1☐ M 2☒ F	45 Yrs.			MARCH 15 1953	DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	MONTGOMERY	DERWOOD	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
16609 LEOPOLD TERR	20855	UNITED STATES

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yaar or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	TEACHER	MONTGOMERY COUNTY PUBLIC SCHOOLS

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
BEN FRIEDMAN	BEATRICE LUX

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
CRAIG BARUCH (HUSBAND)	16609 LEOPOLD TERRACE, DERWOOD MD 20855

20a. Method of Disposition	20b. Place of Dispoaition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	JUDEAN MEMORIAL GARDENS	5/14/98	OLNEY, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Robert Summers	DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CORONARY ARTERY DISSECTION	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how Injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☒ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
Stephen S. Radentz M.D.	O.C.M.E.	MAY 12, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Dey, Year)	32. Registrar's Signature
MAY 15 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16283

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
ELMA	BEARDEN	MAY	6	1998	12:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ELTERN HAUSE	DAYTON	HOWARD

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
549-52-9587	1☐ M 2☒ F	88 Yrs.					12/14/09	COLORADO

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	PRINCE GEORGES	LAUREL	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13108 LARCH DALE ROAD APT. 4	20708	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		SCHOOL BUS DRIVER	SCHOOL SYSTEM

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ROY MONTAQUE	LILLIAN OSBORN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JUNAMAE WEGNER / DAUGHTER	13108 LARCH DALE RD. APT. 4 LAUREL MD 20708

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	GEORGE WASHINGTON CEMETERY	5/8/98	ADELPHI MARYLAND

21. Signature of Funeral Service Licensee: Robert Mackey

22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. PNEUMONIA	WEEK
	Due to (or as a consequence of):	
	b. ATHERSCLEROSIS	YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	c. CEBROVASCULAR ACCIDENT	YEARS
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D31172

29d. Date signed (Month, Day, Year): MAY 6, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. OKEN 3460 ELLICOTT CENTER DRIVE SUITE 103 ELLICOTT MARYLAND 21043

State Registrar

31. Date filed (Month, Day, Year): MAY 11 1998

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16284

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elizabeth A. Beall

2. Date of Death Month Day Year: May 12, 1998

3. Time of Death: 5:55AM

4e. Facility Name *(If not institution, give street and number)*: Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 215-76-7579

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 20, 1938

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10e. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14374 Cape May Road

10f. Zip Code: 20904

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Never Worked

16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: Arthur Beall

18. Mother's Name *(First, Middle, Maiden Surname)*: Helen Gibson

19a. Informant's Name/Relationship *(Type, Print)*: William R. Wheeler (cousin)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14374 Cape May Road, Silver Spring, MD 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Burtonsville Union Cemetery | Date: 5/14/98

20c. Location - City or Town, State: Burtonsville, MD

21. Signature of Funeral Service Licensee: ▶ William L Boyd

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. UROSEPSIS — 4 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Abeda Ali Khan M.D.

29c. License number: D43323

29d. Date signed *(Month, Day, Year)*: May, 13 1998.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Abeda Ali Khan 18111 PRINCE PHILIP DRIVE SUITE 111, OLNEY MD 20832.

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 14 1998

32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

JW

4

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16285

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Merle M. Beckett
2. Date of Death (Month, Day, Year): May 8, 1998
3. Time of Death: 12:40 am
4a. Facility Name (If not institution, give street and number): Wilson Healthcare
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 547-32-7508
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): June 24, 1900
9. Birthplace (State or Foreign Country): Michigan

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 201 Russell Avenue
10f. Zip Code: 20877
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: white

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Fathar's Name (First, Middle, Last): Harley Manring
18. Mother's Name (First, Middle, Malden Surnema): Edna Bailey

19a. Informant's Name/Relationship (Type, Print): Donald F. Beckett (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 596, Wicomico, Virginia 23184

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cematary, cramatory or other place): Chesapeake Crematory
Date: 5/10/98
20c. Location - City or Town, Stata: Beltsville, Maryland

21. Signature of Funeral Service Licensee: (M00956)
22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final diseasa or condition resulting in death): a. Pneumonia — Days

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic Heart Disease

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☑ No

25. Was casa referred to medical examinar? 1☐ Yes 2☑ No

28. Placa of Death (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: 020516
29d. Date signed (Month, Day, Year): 05/08/98

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print): Joel Schulman, MD 9410 Old Georgetown Rd. Bethesda, Md. 20814

State Registrar

31. Date filed (Month, Day, Year): MAY 11 1998
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

RKD

98-2659-031

DANIEL BERNSEN

AMEND: #8 PER INFORMANT G762 8-31-98 WR.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 16286

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
DANIEL	M.	BERNSEN	MAY	11,	1998	8:45A.M.

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
12013 BRONZEGATE PLACE	SILVER SPRING	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
521-67-8770	1☒M 2☐F	21 Yrs.					~~JULY 23, 1976~~ 2-28-76	NEW MEXICO

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	MONTGOMERY	SILVER SPRING	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
12013 BRONZEGATE PL.	20910	U.S.A.

11. Maritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Yeer or Dates: 1994-1998	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
12		U.S. AIR FORCE	DEFENSE

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
PATRIC BERNSEN	KELLIE JACKSON

19a. Informent's Neme/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
EUDORA BERNSEN/WIFE	574½ 34th RD., CLIFTON, CO. 81520

20e. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Locetion - City or Town, State
1☐Buriel 2☒Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)	CHAMBERS CREMATORY	5/13/98	RIVERDALE, MD.

21. Signature of Funerel Service Licensee: ▶ W.W. Chambers MO0091

22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD.20737

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Final diseese or condition resulting in death)
a. Intra oral Shotgun wound

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Last
b.

Due to (or es e consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was en eutopsy performed? Limited 1☒Yes 2☐No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☐Neturel 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year): Found 5-11-98

28b. Time of Injury: unknown M

28c. Injury et Work? 1☐Yes 2☒No

28d. Describe how injury occurred: subject shot self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home

28f. Location (Street and Number or Rural Route Number, City or Town, Stete): 12013 Bronzegate Place Montgomery County, Maryland

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner es stated. 2☒ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signeture end title of certifier: ▶ Mitchell S. Wadtz, MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): MAY 12, 1998

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): MAY 15 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16287

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LILY BLANKSTEIN
2. Date of Death Month Day Year: APRIL 28 98
3. Time of Death: 17:05 P.
4a. Facility Name (If not institution, give street and number): 10125 SORREL AVE.
4b. City, Town, or Location of Death: POTOMAC
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 214-52-4149
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 51 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 12, 1947
9. Birthplace (State or Foreign Country): GERMANY

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: POTOMAC
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10125 SORREL AVE.
10f. Zip Code: 20854
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PRODUCER
16b. Kind of Business/Industry: MEDIA

17. Father's Name (First, Middle, Last): SOL (REICH) DASH
18. Mother's Name (First, Middle, Maiden Surname): PAULA GARFINKEL

19a. Informent's Neme/Relationship (Type, Print): MITCHELL BLANKSTEIN / HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10125 SORREL AVE. POTOMAC, MD 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): MT. LEBANON CEMETERY
Date: 4/30/98
20c. Location - City or Town, State: ADELPHI, MD

21. Signature of Funeral Service Licensee: DANIEL SIMONS
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Finel disease or condition resulting in death)	e. OVERDOSE	ACUTE
	Due to (or es e consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last	b. Due to (or as a consequenca of):	
	c. Due to (or as e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DEPRESSION

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Piece of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Deeth: 1☐ Naturel 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): APRIL 25 98
28b. Time of Injury: P M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: ALOCHOL PLUS PILLS
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify): HOME
28f. Location (Street and Number or Rural Route Number, City or Town, State): #10

29a. Certifier (Check only one): 1☐ Certifying Phyeician: To the best of my knowledge, death occurred at the time, dete end placa, and due to the cause(s) end menner as steted. 2☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Francis C Mayle MD
29c. License number: D07099
29d. Date signed (Month, Day, Year): APRIL 28 98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCIS C MAYLE 1025 FERNWOOD RD BETHESDA MD 20817

State Registrar

31. Date filed (Month, Day, Year): MAY 11 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16288

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frieda M. Blumenthal
2. Date of Death (Month, Day, Year): May 11, 1998
3. Time of Death: 1:25 PM
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 147-24-2264
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 19, 1905
9. Birthplace (State or Foreign Country): Germany

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6503 Wilmett Road
10f. Zip Code: 20817
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Goldsmith
16b. Kind of Business/Industry: Jewelry

17. Father's Name (First, Middle, Last): Franz Michaelis
18. Mother's Name (First, Middle, Maiden Surname): Rosa Jacobsohn

19a. Informant's Name/Relationship (Type, Print): Ralph B. Blumenthal/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 41 Stoney Brook Rd., Holmdel, New Jersey 07733

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. Date: May 13, 1998
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Ralph Faul M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Pneumonia
Sepsis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: G. Gupta
29c. License number: D46398
29d. Date signed (Month, Day, Year): May 12th, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): G. Gupta, M.D. 121 Congressional Lane #409, Rockville, Maryland 20852

State Registrar

31. Date filed (Month, Day, Year): MAY 14 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Frieda Blumenthal 5-11-98 1325 JW

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16289

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Placido Bovello

2. Date of Death (Month, Day, Year): May 7, 1998

3. Time of Death: 12:57 PM

4a. Facility Name (If not institution, give street and number): Mariner Health Care of Silver Spring

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-36-6727

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 18, 1929

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8109 Tahona Drive, G-1

10f. Zip Code: 20903

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1950-1952

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): musician

16b. Kind of Business/Industry: entertainment

17. Father's Name (First, Middle, Last): Angelo E. Bovello

18. Mother's Name (First, Middle, Maiden Surname): Angelina Mary Bruno

19a. Informant's Name/Relationship (Type, Print): Dorothy Bovello (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8109 Tahona Drive, #201, Silver Spring, MD 20903

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory

Date: 5-8-98

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Carol A Dehn

22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Lung Cancer, metastatic — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [X] **Yes** 2 [ ] No 3 [ ] **Probably** 4 [ ] **Unknown**

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Barr, MD

29c. License number: D21611

29d. Date signed (Month, Day, Year): May 7, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Barr, M.D., 10810 Connecticut Avenue, Kensington, Maryland 20895

State Registrar

31. Date filed (Month, Day, Year): MAY 11 1998

32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

(5)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16290

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARIA T. BRADFORD

2. Date of Death Month Day Year: MAY 8, 1998

3. Time of Death: 8:35AM

4a. Facility Name *(If not institution, give street and number)*: 10325 SEVEN LOCKS RD.

4b. City, Town, or Location of Death: POTOMAC

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-46-0999

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JULY 8, 1935

9. Birthplace *(State or Foreign Country)*: NEW YORK

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: POTOMAC

10d. Inside City Limits: 1☐ Yes 2☐ No X

10e. Street and Number: 10325 SEVEN LOCKS RD

10f. Zip Code: 20854

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☒ Yes 2☐ No *Specify:* CUBAN

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: ENRIQUE TOUCIDA

18. Mother's Name *(First, Middle, Maiden Surname)*: HELEN VAN LOAN

19a. Informent's Neme/Reletionship *(Type, Print)*: DOUGLAS BRADFORD - SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 101 IDLEWILD ROAD SEVERNA PARK, MD 21146

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: PARKLAWN MEMORIAL PARK

Dete: 5/12/98

20c. Location - City or Town, State: ROCKVILLE, MD

21. Signature of Funeral Service Licensee: Jeffry A. Gawler

22. Name and Address of Facility: JOSEPH GAWLER'S SONS INC 5130 WISCONSIN AVE NW WASHINGTON, DC 20016

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION — MINUTES

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end piece, end due to the ceuse(s) end menner es stated. 2☒ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete and ptece, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: Francis C. Mayle Jr. MD

29c. License number: D07099

29d. Date signed *(Month, Day, Year)*: May 9, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCIS C. MAYLE JR. MD., 10215 FERNWOOD RD., #301 BETHESDA, MD 20817

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 11 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16291

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Beatrix L. Brodsky
2. Date of Death Month / Day / Year: May 10, 1998
3. Time of Death: 8:00 AM
4a. Facility Name *(If not institution, give street and number)*: Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 074-05-4686
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 27, 1911
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3701 International Drive, #430
10f. Zip Code: 20906
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 1
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Editor
16b. Kind of Business/Industry: National Institutes of Health

17. Father's Name *(First, Middle, Last)*: Meyer Lewis
18. Mother's Name *(First, Middle, Maiden Surname)*: Freda Arkin

19a. Informant's Name/Relationship *(Type, Print)*: Jackson Brodsky/Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3701 International Drive, #430, Silver Spring, MD 20906

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc. — Date: May 11, 1998
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: [signature] M01126
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. ~~Ist only one~~ cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE SUBDURAL HEMATOMA WITH MIDLINE — 8 DAYS
Due to (or as a consequence of):
b. SHIFT AND UNCAL HERNIATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceusa (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
TYPE II DIABETES MELLITUS
HYPERTENSION
HISTORY OF STROKES

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D35045
29d. Date signed *(Month, Day, Year)*: May 10, 1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PHILIP G. HENSUM, MD 3416 OLANDWOOD COURT #200 OLNEY, MD 20832

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 11 1998
32. Registrar's Signature: [signature] Julia Davidson-Randell

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16292

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Annabelle Burns
2. Date of Death Month Day Year: May 10, 1998
3. Time of Death: 11:00 AM
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-20-7218
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 2, 1921
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4318 Lynbrook Drive
10f. Zip Code: 20814
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, atc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Security
16b. Kind of Business/Industry: Telephone Company

17. Father's Name (First, Middle, Last): Harmon Burns
18. Mother's Name (First, Middle, Maiden Surname): Maybelle McCarthy

19a. Informent's Name/Relationship (Type, Print): George L. Griesbauer, Jr./nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2920 Birchtree Lane, Silver Spring, MD 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other placa): Mt. Olivet Cemetery
Date: May 13, 1998
20c. Locetion - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensae: Ray Faul M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Stroke — Days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditiona** contributing to death but not rasulting in the underlying cause given in Part I.: Acute Lower Extremity Ischemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homlcide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Richard L. Feinberg
29c. License number: D42865
29d. Data signed (Month, Day, Year): May 11, 1998

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): Richard L. Feinberg, M.D. 8218 Wisconsin Avenue, Bethesda, Maryland 20814

State Registrar

31. Date filed (Month, Day, Year): MAY 14 1998
32. Registrar's Signeture: Julia Davidson-Randell

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Annabelle Burns 5/10/98 11A

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16293

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Panagiota C. Bagdasian	A.K.A. Pauline C. Bagdasian	May 13, 1998	8:15 AM

4a. Facility Name (If not Institution, giva street and number)	4b. City, Town, or Location of Death	4c. County of Death
Suburban Hospital	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yaar: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-18-5842	1☐ M 2☒ F	75 Yrs.					Jan. 14, 1923	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Silver Spring	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizan of What Country?
10224 Colesville Road	20901	USA

11. Marital Status	12. Was Decedant Ever In U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.)	14. Race - Americen Indian, Black, White, etc.
1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☒ Yas 2☐ No If Yes, Give Year or Dates: 1945-51	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	3	Registered Nurse	Health Care

17. Fathar's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
Nicolas Cocoros	Jennie Sarantakos

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rozanne M. Lyons (daughter)	8311 Berwick Road, Upper Marlboro, MD 20772

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)	MD Veteran's Cemetery	5/19/98	Cheltenham, MD

21. Signature of Funeral Sarvice Licensee ▶ William L Byrd

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours aftar death with tha Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Entar the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona causa on each line.

Approximate Intarval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Nonsmall Cell Lung Cancer — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was cese referred to medicel examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Data of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Routa Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ David A Holden MD	047791	May 14, 1998

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)
David A Holden MD 809 Veirs Mill Rd, Rockville, MD 20851

To the Hospital or Attending Physician: Tha law requires thet the death certificata be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by tha funeral director, paga 2 should be detached for usa as the burial-transit

Division of Vital Records, P.O. Box 68760,

Panagiota C. Bagdasian 5-13-98 8:15 AM

Bud

20 1g

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 15 1998	▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16294

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret R. Bunt-Wagner
2. Date of Death (Month, Day, Year): May 7, 1998
3. Time of Death: 6:15PM
4a. Facility Name (If not institution, give street and number): 3996 Farm Lane
4b. City, Town, or Location of Death: Monrovia
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 209-20-6114
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 70 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 24, 1928
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Pa.
10b. County: Cambria
10c. City, Town or Location: Johnstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: A49 Arbutus Village
10f. Zip Code: 15904
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HomemAker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Harry Reese
18. Mother's Name (First, Middle, Maiden Surname): Clara Wilson

19a. Informant's Name/Relationship (Type, Print): Stephanie J. Atkins/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3996 Farm Lane, Monrovia, Md. 21770

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Forest Lawn Cem.
Date: 5/12
20c. Location - City or Town, State: Johnstown, Pa.

21. Signature of Funeral Service Licensee: Fred C. Burner
22. Name and Address of Facility: Burner Trade Services 1037 DualPlace Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Extensive Gastric Ca — 2 years
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D14626
29d. Date signed (Month, Day, Year): May 8, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): P. Gregory Rausch M.D. 501 W. Seventh St. Frederick, Md. 21701

State Registrar

31. Date filed (Month, Day, Year): MAY 11 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16295

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN HENRY BIVENS

2. Date of Death (Month, Day, Year): MAY 11, 1998

3. Time of Death: 1745

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 220-18-1554

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 28, 1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 16425 Shinham Road

10f. Zip Code: 21740

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sign Department

16b. Kind of Business/Industry: State Highway Administration

17. Father's Name (First, Middle, Last): Samuel Ralph Bivens

18. Mother's Name (First, Middle, Maiden Surname): Anna Gertrude Hoke

19a. Informant's Name/Relationship (Type, Print): Vallie M. Bivens, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16425 Shinham Road, Hagerstown, Maryland 21740

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Cedar Lawn Memorial Park

Date: May 16

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Douglas A Fiery

22. Name and Address of Facility: Douglas A. Fiery Funeral Home, 1331 Eastern Blvd. N., Hagerstown, Maryland 21742

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Finel disease or condition resulting in death) e.	Bilateral Pneumonia	72hrs
Due to (or as a consequenca of): b.	Lymphoma	4mos.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest — Due to (or as a consequence of): c.	Chronic Myeloceytic Leukemia	2yrs
Due to (or as a consequence of): d.	Chronic Obstructive Pulmonary Disease	15yrs

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Tobacco Abuse
Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: [signature]

29c. License number: D50738

29d. Date signed (Month, Day, Year): 5/12/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sandra Fowler MD 239 N. Potomac Street Hagerstown MD 21740

State Registrar

31. Date filed (Month, Day, Year): MAY 15 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16296

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Russell Baker
2. Date of Death: Month 05 Day 10 Year 98
3. Time of Death: 0235
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 220-09-7438
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 4, 1916
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Pennsylvania
10b. County: Franklin
10c. City, Town or Location: Greencastle
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 26 East Baltimore Street
10f. Zip Code: 17225
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0-8 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): electrician
16b. Kind of Business/Industry: cement company

17. Father's Name (First, Middle, Last): Samuel Evers Baker
18. Mother's Name (First, Middle, Maiden Surname): Florence Elizabeth Fisher

19a. Informant's Name/Relationship (Type, Print): Mrs. Peggy L. Baker/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26 East Baltimore Street, Greencastle, Pennsylvania 17225

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Lawn Memorial Park
Date: May 13, 1998
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott Minnich
22. Name and Address of Facility: Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Arteriosclerotic cardiovascular disease weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Stroke, Hypertension, chronic obstructive lung disease, Renal Failure, Diabetes mellitus Type

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D26806
29d. Date signed (Month, Day, Year): 05/10/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Allan D. Haws 747 Northern Ave Hagerstown MD 21742

State Registrar

31. Date filed (Month, Day, Year): MAY 11 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Charles Russel Baker

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16297

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lillian M. Baker

2. Date of Death: Month May Day 9 Year 1998

3. Time of Death: 5:00AM

4a. Facility Name (If not institution, give street and number): Genesis ElderCare - The Pines

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 219-16-5364

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT. 4, 1904

9. Birthplace (State or Foreign Country): Chester, MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Talbot

10c. City, Town or Location: Easton

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 107 Park Lane

10f. Zip Code: 21601

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Domestic/Own Home

17. Father's Name (First, Middle, Last): Cleveland Johnson

18. Mother's Name (First, Middle, Maiden Surname): Addie Tarbutton

19a. Informant's Name/Relationship (Type, Print): Betty Morris/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 202 Unit J, Clifford Lane, Forest Hill, MD 21050

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Memorial Park

Date: May 14, 1998

20c. Location - City or Town, State: Easton, Maryland

21. Signature of Funeral Service Licensee: ▶ JOHN R. MERCER CFSP

22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 200 S. Harrison Street, Easton, Maryland 21601

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CEREBRAL VASCULAR ACCIDENTS — DAYS

Due to (or as a consequence of):

b. HYPERTENSION — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ DO

29c. License number: H48241

29d. Date signed (Month, Day, Year): 5/11/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DANIEL E. MAKAS, DO 508 INLEWILD AVE EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year): MAY 13 1998

32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16298

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marjorie May Clendening
2. Date of Death Month / Day / Year: May 6, 1998
3. Time of Death: 11:45 p.m.
4a. Facility Name *(If not institution, give street and number)*: Magnolia Hall, Inc
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 219-36-5892
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 98 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 15, 1899
9. Birthplace *(State or Foreign Country)*: Barclay, MD

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Millington
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 318 W. Cypress
10f. Zip Code: 21651
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT usa retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Fathar's Name *(First, Middle, Last)*: George B. Clendening
18. Mother's Name *(First, Middle, Meiden Surnama)*: Julia J. Johnson

19a. Informent's Name/Relationship *(Type, Print)*: Ed Baxter
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*:

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Sudlersville Cemetery
Date: May 11, 1998
20c. Location - City or Town, State: Sudlersville, MD

21. Signatura of Funaral Service Licensea: ▶ Kirk J. Helfenbein
22. Name and Address of Facility: Fellows, Helfenbein, & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complications thet caused the daath. Do not entar the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. — Approximate Interval Between Onset and Death

Immediate Cause (Finai disaase or condition resulting in daath)
a. Arteriosclerotic cardiovascular disease — years

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury thet initiated events resulting in death) Lest
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Severe Osteoporosis and osteoarthritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Rasidenca 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Phyeician:** To the best of my knowledge, deeth occurred at the time, date and piece, end due to the cause(s) end manner as steted. 2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and piaca, and due to the cause(s) and manner stated.

29b. Signatura and title of cartifier: ▶ G. Brannan
29c. License number: D00 354
29d. Data signed *(Month, Dey, Year)*: 5/8/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): C.G. Brannan MD 6602 Church Hill Rd Chestertown, Md 21620

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 11 '98
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16299

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
VALERIE VIRGINIA CLARK	MAY 12, 1998	4:00 PM.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4152 LOUISVILLE RD.	FINKSBURG	CARROLL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-26-3169	1☐ M 2☒ F	69 Yrs.			9/6/1928	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	CARROLL	FINKSBURG	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4152 LOUISVILLE RD.	21048	USA.

11. Marital Status	12. Was Decedent Ever In U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOUSEWIFE	HOMEMAKER

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
HARRY HAINES	MARGARITE TAYLOR

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ADRIENNE CHRISTIAN-DAUGHTER	4152 LOUISVILLE RD.,FINKSBURG, MD. 21048

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	METRO CREMATORY	5/13/98	BALTIMORE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive Heart Failure	2 month
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Robert J. Moss	032882	5/13/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert L. Moss 114 Business Center Dr. Reisterstown, Md 21136

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 13 1998	[signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

98 16300

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Kathleen Grace Curry			2. DATE OF DEATH (Month, Day, Year): May 10 1998	3. TIME OF DEATH: 8:45 A M
4. SOCIAL SECURITY NUMBER: 109-10-6405	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 28, 1916	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Glade Valley Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH: Walkersville		9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Walkersville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 56 West Frederick Street		10f. ZIP CODE: 21793	10g. CITIZEN OF WHAT COUNTRY? United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: own home	
17. FATHER'S NAME (First, Middle, Last): Joseph Ward Bird		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosamond Viola Darrah	
19a. INFORMANT'S NAME (Type/Print): Nancy K. Strosnider Daughter		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4102 Sequoia Drive Westminster, MD 21157	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Resthaven Memorial Gardens	DATE: 5/13	20c. LOCATION — City or Town, State: Frederick, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Tamra B Cooney		22. NAME AND ADDRESS OF FACILITY: Burrier-Queen Funeral Directors, P.A. 21784 1212 W. Old Liberty Road Winfield, MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute Myocardial Infarction	1 day
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	Atherosclerotic Cardiovascular dis	years
DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multi Infarct Dementia
Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Allen J. Gilson MD	29c. LICENSE NUMBER: D26574	29d. DATE SIGNED (Month, Day, Year): ▶ MAY 11 1998
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Allen J. Gilson MD 1475 TANEY AVE FRED MD 21702		
31. DATE FILED (Month, Day, Year): MAY 12 1998	32. REGISTRAR'S SIGNATURE: Julia Thurber Randall	

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16301

Amend #7, 5/11/98, BMW, Montg. Co.

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Marie S. Collins	May 9, 1998	4:05 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Brooke Grove Rehabilitation & Nursing Center	Sandy Spring	Montgomery

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-14-5159	1☐ M 2☒ F	~~89~~ 90 Yrs.			Aug. 2, 1907	New York

Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4 Fitzhugh Court	20906	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Office Manager	Insurance

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Favian J. Benson	Signe Peterson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Robert A. Collins (son)	3706 Rolison Road-Space 5, Redwood City, CA 94063

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Chesapeake Crematory	5-11-98	Beltsville, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Carol a Dahn	Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE MYOCARDIAL INFARCTION	IMMEDIATE
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. CORONARY HEART DISEASE	10 YEARS
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ James a Rossi MD	D24543	MAY 11, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
James A. Rossi, M. D., 3305 North Leisure World Blvd., Silver Spring, MD 20906

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 11 1998	Julie Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16302

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FREELAND HENRY CARDE, III
2. Date of Death Month Day Year: MAY 12 1998
3. Time of Death: 10:33 PM
4a. Facility Name (If not institution, give street and number): NATIONAL NAVAL MEDICAL CENTER
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 066-40-0312
6. Sex: X M 2☐ F
7. Age (In yrs. last birthday): 51 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 3, 1947
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State:
10b. County:
10c. City, Town or Location: Washington, DC
10d. Inside City Limits: X Yes 2☐ No
10e. Street and Number: 732 11th Street, SE
10f. Zip Code: 20003
10g. Citizen of What Country? United States

11. Marital Status: 1☐X Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐X Yes 2☐ No If Yes, Give Year or Dates: 1968-1988
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☐X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Naval Officer
16b. Kind of Business/Industry: U. S. Navy Naval Intelligence

17. Father's Name (First, Middle, Last): Freeland H. Carde, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Marybelle Finger

19a. Informant's Name/Relationship (Type, Print): Marybelle Carde (mother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): #730 3310 N. Leisure World Blvd., Silver Spring, MD 20906

20a. Method of Disposition: 1☐ Burial 2☐X Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 5-14-98
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: ▶ James J. Rapp
22. Name and Address of Facility: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ACQUIRED IMMUNE DEFICIENCY SYNDROME

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ J. A. Eastone, M.D.
29c. License number: MD-0000028855 (TN)
29d. Date signed (Month, Day, Year): 5/13/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J.A.EASTONE, LT, MC, USN
NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

State Registrar

31. Date filed (Month, Day, Year): MAY 15 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Blue

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16303

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SYLVIA MOLLY NOVEY CEDERLOFF

2. Date of Death Month: May Day: 12, Year: 1998

3. Time of Death: 5:00pm

4a. Facility Name *(If not institution, give street and number)*: 13901 Blair Stone Lane

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-07-9666

8. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct.9,1920

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decadent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 13901 Blair Stone Lane

10f. Zip Code: 20906

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Jacob Novey

18. Mother's Name *(First, Middle, Maiden Surname)*: Ethel Cohen

19a. Informant's Name/Relationship *(Type, Print)*: Carole Ratner/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2905 Red Lion Ln Silver Spring,MD 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Norbeck Mem. Park

Date: 5/15/98

20c. Location - City or Town, State: Olney, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Ives-Pearson Funeral Home 2847 Wilson Blvd. Arlington, VA 22201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. non Hodgkins Lymphoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated.

29b. Signatura and title of certifier: Bernard a. Heckman, M.D.

29c. Licansa number: 005373

29d. Date signed *(Month, Day, Year)*: 5-13-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bernard A. Heckman,M.D. 8830 Cameron St, Silver Spring, MD 20910

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 15 1998

32. Registrar's Signature: Julia Davidson-Randell

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16304

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Data of Death Month	Day	Yaar	3. Tima of Death
Nancy	Chapwick	May	8,	1998	11:45 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
20256 Waters Row Terrace	Germantown	Montgomery

Funeral Director

5. Social Security Number	6. Sax	7. Age (In yrs. last birthday)	If Under 1 Yeer Months	Days	If Under 24 Hrs. Hours	Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
185-34-0563	1☐ M 2☒ F	56 Yrs.					Feb. 13, 1942	Pennsylvania

Usual Residance of Decedant

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Germantown	1☐ Yas 2☒ No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
20256 Waters Row Terrace	20874	United States

11. Marital Status	12. Was Decadant Evar in U.S. Armed Forces?	13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.)	14. Raca - Amarican Indian, Black, Whita, atc.
1☐ Navar Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yas 2☒ No If Yes, Giva Yaar or Datas:	1☐ Yas 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elamantary/Secondary (0-12)	Collega (1-4or 5+)		
	2	Secretary	Federal Government

17. Fathar's Nama (First, Middle, Last)	18. Mothar's Nama (First, Middle, Maidan Surname)
Donald Emerick	Margaret Snyder

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Michelle Hodos/Daughter	6903 Summerwood Drive, Frederick, Maryland 21702

20a. Mathod of Disposition	20b. Placa of Disposition (Name of cametery, crematory or other placa)	Data	20c. Location - City or Town, State
1☐ Burial 2☒ Crametion 3☐ Ramoval from State 4☐ Donation 5☐ Othar (Specify)	Metropolitan Crematory	5/9/98	Alexandria, Virginia

21. Signature of Funeral Service Licensee ▶ Michael D Culbert

22. Nama and Address of Facility DeVol Funeral Home 10 East Deer Park dr., Gaithersburg, MD. 20877

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complicetions thet caused the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

		Approximata Intarval Batween Onset and Death
Immediete Causa (Final disaasa or condition rasulting in death) a.	Bowel obstruction	8 weeks
Dua to (or as a consaquanca of): b.	Metastatic ovarian cancer	4 years
Sequentielly list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last: Dua to (or as a consaquanca of): c.		
Due to (or as a consequanca of): d.		

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?
1☐ Yas 2☒ No	1☐ Yas 2☐ No

25. Was casa rafarrad to medical axaminar?	26. Placa of Daath (Chack only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Homa 5☒ Rasidanca 6☐ Othar (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined		M	1☐ Yas 2☐ No	
	28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar (Check only one) 1☒ **Certifying Physician:** To tha best of my knowledge, daath occurred at tha tima, data and placa, and dua to the cause(s) and mannar as stated. 2☐ **Medicaf Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at the tima, data and placa, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifier	29c. Licansa number	29d. Data signed (Month, Day, Year)
▶ Albert J. Steren	D38682	May 9, 1998

30. Nama and addrass of parson who compiatad causa of daath (Item 23a) (Type, Print)

Albert J. Steren, M.D., 9715 Medical Center Dr., # 436, Rockville, MD. 20850

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
MAY 11 1998	▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16305

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Parker Coleman
2. Date of Death (Month, Day, Year): May 11, 1998
3. Time of Death: 1:30 AM
4e. Facility Name (If not institution, give street and number): Mariner Health of Bethesda
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-52-0841
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 29, 1915
9. Birthplace (State or Foreign Country): Panama

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street end Number: 6304 Marjory Lane
10f. Zip Code: 20817
10g. Citizen of Whet Country?: United States

11. Meritel Stetus: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Reca - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 5+
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Episcopal Clergyman
16b. Kind of Business/Industry: Religion / Episcopal Church

17. Fether's Neme (First, Middle, Last): Albert James Coleman
18. Mother's Neme (First, Middle, Meiden Sumeme): Edith Shaw

19e. Informent's Neme/Reletionship (Type, Print): Mildred G. Coleman (wife)
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): Same as 10

20e. Method of Disposition: 1 ☐ Buriel 2 ☒ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Chesapeake Crematory
Dete: 5-11-98
20c. Locetion - City or Town, Stete: Beltsville, Maryland

21. Signature of Funeral Service Licensee: ▶ Ellen H. Rapp
22. Name and Address of Feciility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line. — Approximate Intervel Between Onset end Deeth

Immedlete Ceuse (Finel diseese or condition resulting in death)
e. Pulmonary Edema
Due to (or as a consequence of):
Sequentielly list conditions, if eny, leeding to Immediete cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in deeth) Lest
b. Congestive Heart Failure
Due to (or es e consequence of):
c.
Due lo (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Diabetes II; Dementia; Renal Failure

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Wes en autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings eveileble prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☒ No
26. Piece of Deeth (Check only one): Hospitel: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA | Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Deeth: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)
28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) and menner as stated. 2 ☐ **Medical Examiner**: On the besis of exemination end/or investigation, in my opinion, death occurred at the time, dete end piece, end due to the ceuse(s) and meiner steted.

29b. Signeture and title of certifier: ▶ Elliot R. Goldstein
29c. License number: D 03581
29d. Dete signed (Month, Day, Year): May 11, 1998

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): Elliot R. Goldstein, M. D., 9410 Old Georgetown Road Bethesda, Maryland 20814

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 11 1998
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Bmw

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16306

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BRONISLAWA VERONICA CZAJKOWSKI
2. Date of Death Month / Day / Year: MAY 12 1998
3. Time of Death: 7:45 PM
4a. Facility Name *(If not institution, give street and number)*: NATIONAL NAVAL MEDICAL CENTER
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 081-05-7101
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 29,1917
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4310 Kentbury Drive
10f. Zip Code: 20814
10g. Citizen of Whet Country?: United States

11. Merital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorcad
12. Wes Decedent Ever in U,S. Armed Forces?: 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decadent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): - ; College (1-4or 5+): 2
16a. Decadent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Vincent Sunday
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Josephine Strelczun

19a. Informent's Neme/Reletionship *(Type, Print)*: Anthony F. Czajkowski/ Husband
19b. Malling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 4310 Kentbury Drive, Bethesda, Maryland 20814

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removef from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, cremetory or other piece)*: Arlington National Cemetery — Date: May 19,1998
20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: ▶ [signature] M00689
22. Neme end Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line. — Approximate Interval Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in death): e. MYOCARDIAL INFARCTION

Due to (or es a consequence of):

Sequentielly list conditions, if eny, leading to Immediete cause. Enter Underlying Ceuse (Diseese or injury thet Initieted events resulting in death) Lest:

b. CORONARY ARTERY DISEASE

Due to (or as e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?: 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed?: 1☐ Yes 2☒ No

24b. Were eutopsy findings availeble prior to completion of cause of deeth?: 1☐ Yes 2☐ No

25. Wes case referred to medical examiner?: 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury et Work?: 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, and due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner stated.

29b. Signature and title of certifier: ▶ B. W. Mandeville, MD.
29c. License number: 39490 (WI)
29d. Date signed *(Month, Dey, Year)*: 5/13/98

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): B. W. MANDEVILLE, LT, MC, USN — NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Dete filed *(Month, Day, Yeer)*: MAY 14 1998
32. Registrer's Signeture: ▶ Julia Davidson-Randell

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 16307

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gladys W. Carbaugh

2. Date of Death: Month MAY Day 10 Year 1998

3. Time of Death: 9:10a

4a. Facility Name *(If not institution, give street and number)*: THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 201-16-2370

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 1/31/1921

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: PA

10b. County: Franklin

10c. City, Town or Location: Chambersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 278 W. Burkhart Avenue

10f. Zip Code: 17201

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housekeeper

16b. Kind of Business/Industry: Hotel/Motel

17. Father's Name *(First, Middle, Last)*: Edward G. Jones

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary C. Carbaugh

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Terence W. Carbaugh - Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 875 Edenville Road Chambersburg, PA 17201

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lincoln Cemetery | Date: 5/13/98

20c. Location - City or Town, State: Chambersburg, PA

21. Signature of Funeral Service Licensee: Ted E. Geisel

22. Name and Address of Facility: Thomas L. Geisel Funeral Home, Inc. 333 FAlling Spring Road Chambersburg, PA 17201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Sepsis	6 days
Due to (or as a consequence of): b.	Acute Renal Failure	10 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Staphylococcal osteomyelitis of spine	1 month
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Stress gastritis

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David G. Kaplan

29c. License number: RES-000

29d. Date signed *(Month, Day, Year)*: May tenth, nineteen ninety eight

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DAVID KAPLAN, MD 600 N. WOLFE ST., BALTIMORE MD 21287

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 13 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16308

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM HENRY CONN
2. Date of Death — Month: MAY 9 Day: 1998 Year:
3. Time of Death: 7:30 AM
4a. Facility Name (If not institution, give street and number): 6016-2 New Forest Court
4b. City, Town, or Location of Death: WALDORF
4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 578 22 3576
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 13, 1912
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6016-2 New Forest Court
10f. Zip Code: 20603
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinists
16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): William Conn
18. Mother's Name (First, Middle, Maiden Surname): Hannah Elevels

19a. Informant's Name/Relationship (Type, Print): Genevieve Rhodes Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6825 Cologo Court Waldorf, Maryland 20603

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rest Haven Cemetery
Date: 5/12/98
20c. Location - City or Town, State: Hagerstown, Md.

21. Signature of Funeral Service Licensee: Gerald N. Minnich
22. Name and Address of Facility: Gerald N. Minnich Funeral Home 305 N. Potomac St. Hagerstown, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Bronchogenic carcinoma — 6 months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cerebrovascular disease
Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Caroline Caine MD
29c. License number: D0052741
29d. Date signed (Month, Day, Year): 5/9/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Caroline Caine, MD 700 Old Line Center Suite 100 Waldorf, MD 20602

State Registrar

31. Date filed (Month, Day, Year): MAY 13 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

WILLIAM HENRY CONN

98 16309

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Bruce M. Clipp			2. DATE OF DEATH (Month, Day, Year): May 9, 1998	3. TIME OF DEATH: 1400 M
4. SOCIAL SECURITY NUMBER: 220-18-2187	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 73 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): November 11, 1924	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): 14717 Warfordsburg Road		9b. CITY, TOWN OR LOCATION OF DEATH: Hancock		9c. COUNTY OF DEATH: Washington
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hancock		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 14717 Warfordsburg Road		10f. ZIP CODE: 21750		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Owner/Operator		16b. KIND OF BUSINESS/INDUSTRY: Restaurant
17. FATHER'S NAME (First, Middle, Last): Jesse B. Clipp		18. MOTHER'S NAME (First, Middle, Maiden Surname): Gertrude Drenner		
19a. INFORMANT'S NAME (Type/Print): Gary D. Clipp		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9513 Bell Vernon Place Montgomery Village, MD 20886		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Lawn DATE: 5/13/98		20c. LOCATION — City or Town, State: Hagerstown, MD 21740
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Grove Funeral Home, P.A. 141 West Main St. Hancock, MD 21750-0368		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Cardiovascular Disease	months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D26806	▶05/12/98

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): AWD Hons 747 Northern Ave Hagerstown MD 21742

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAY 14 1998	Julia Davidson-Randall

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16310

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maxine Cain

2. Date of Death (Month, Day, Year): May 13, 1998

3. Time of Death: 12:25 A.M.

4a. Facility Name (If not institution, give street and number): Chestertown Rehabilitation Center

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 213-22-7618

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar. 4, 1929

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Kent

10c. City, Town or Location: Chestertown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 339 Lord Calvert Apartment

10f. Zip Code: 21620

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, spacify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: Black

15. Decadent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: Factory Work

17. Father's Nema (First, Middle, Last): Morris Holland

18. Mother's Name (First, Middle, Maiden Sumame): Lucy Jones

19a. Informant's Name/Relationship (Type, Print): Wayne Alvin Cain, Son

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 839 High Street, Chestertown, Maryland 21620

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Emmanuel Cemetery

Dete: 5/20/98

20c. Location - City or Town, State: (Quaker Neck) Chestertown, Md.

21. Signature of Funeral Service Licensee:

22. Name end Address of Fecility: Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that causad tha daath. Do not enter tha mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final diseese or condition resulting in death) e.	END STAGE RENAL DISEASE	~6 months
Due to (or as e consequenca of):		
Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted avents resulting in death) Last b.	DIABETES	>10 yrs
Due to (or es a consequence of):		
c.		
Due to (or as e consequence of):		
d.		

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.: PULMONARY HYPERTENSION

23b. Did tobacco uas contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end placa, end due to the cause(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at tha time, date end placa, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: Helen A Noble MD

29c. Licanse number: D41587

29d. Data signed (Month, Dey, Year): 5-13-98

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Helen Noble MD, 122 Speer Road, Chestertown, Md. 21620

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 15 1998

32. Registrar's Signeture: Julia Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16311

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Una S. Dodd

2. Date of Death Month / Day / Year: May 10, 1998

3. Time of Death: 6:15 AM

4a. Facility Name *(If not institution, give street and number)*: Genesis Eldercare - Layhill Center

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 214-12-4615

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 20, 1914

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Kensington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3401 Wake Drive

10f. Zip Code: 20895

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 4 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: James Smith

18. Mother's Name *(First, Middle, Maiden Surname)*: Melvina Hodinger

19a. Informant's Name/Relationship *(Type, Print)*: Robert E. Dodd (son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3328 North Pointe Drive, Quinton, VA 23141

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parklawn Memorial Park

Date: 5/13/98

20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: ▶ James H. Stein Jr

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University BLvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Alzhiemer's Disease — yrs.

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest

b. Hypertension

Due to (or as a consequence of):

c. Dementia.

Due to (or as a consequence of):

d. Old CVA's,

Part II. **Other significant conditions** contributing to death but not reaulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end menner as stated. 2☐ **Medical Examinar:** On the basis ot examination and/or investigetion, in my opinion, deeth occurred et the time, date and placa, end due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier: ▶ Suresh Gupta

29c. License number: D14876

29d. Date signed *(Month, Day, Year)*: 5.11.98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Suresh C. Gupta, M.D. 4701 Randolph Rd. Rockville Md. 20852

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 12 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16312

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ruth H. Donlin
2. Date of Death Month Day Year: May 11, 1998
3. Time of Death: 8:00 AM
4a. Facility Name *(If not institution, give street and number)*: Mariner Health Care of Kensington
4b. City, Town, or Location of Death: Kensington
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 296-07-0614
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: September 12,1920
9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7701 New Market Drive
10f. Zip Code: 20817
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12) / College (1-4or 5+): 1
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Neme *(First, Middle, Last)*: Fred B. Handel
18. Mother's Name *(First, Middle, Meiden Surname)*: Mynette S. Voeghtly

19a. Informant's Name/Reletionship *(Type, Print)*: Cheryl D. Doyle/Daughter
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 7701 New Market Drive, Bethesda, Maryland 20817

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc. — Date: May 12, 1998
20c. Location - City or Town, Stete: Bethesda, Maryland

21. Signature of Funeral Service Licensee: ▶ Michael E. Hagen M00846
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Chronic Obstructive Pulmonary Disease	15 Years
	Due to (or as e consequence of):	
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part i.: Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature end title of certifier: ▶ Ralph Nelson
29c. License number: D01191
29d. Dete signed *(Month, Day, Year)*: May 11, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Ralph M. Coan, M.D., 4400 East West Highway, Bethesda, Maryland 20814

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 14 1998
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16313

Amend #20b&20c, 5/15/98, BMW, Montg.Co.

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Gladys M. Dudley	May 10, 1998	2147

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Montgomery General Hospital	Olney	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-18-3559	1☐ M 2☒ F	77 Yrs.			June 10, 1920	Washington, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Silver Spring	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
15115 Interlachen Drive, 614	20906	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Clerk	Clerical

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Karl Cussler	Nora Breen

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Margaret V. McMahon (daughter)	PO Box 821, Berkley Springs, WV 25411

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Gate of Heaven Cemetery ~~Cedar Hill Cemetery~~	5/14/98	Silver Spring, MD ~~Suitland, MD~~

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Steven D Strand	Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

BMW

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarction	IMMediate
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Pneumonia	12 Days
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary bypass Surgery

Cerebrovascular Accident

Hypothyroidism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D18726	May 11, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ARTHUR SCHOEN GOLD, MD 18111 Prince Philip Dr, OLNEY, MD 20832

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 12 1998	Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12

DHMH 16 Rev 6/95

98 16314

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Evelyn Mae Williams Duke			2. DATE OF DEATH (Month, Day, Year): May 11 1998	3. TIME OF DEATH: 2230 M
4. SOCIAL SECURITY NUMBER: 214 09 9854	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept 7 1913	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Washington County Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: Washington
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 11 West Baltimore Street		10f. ZIP CODE: 21740		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Production		16b. KIND OF BUSINESS/INDUSTRY: Aircraft Assembly
17. FATHER'S NAME (First, Middle, Last): Charles Andrew Williams		18. MOTHER'S NAME (First, Middle, Maiden Surname): Berth Hall Williams		
19a. INFORMANT'S NAME (Type/Print): Carolyn Brooks		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 40 ENorth Ave. Hagerstown MD. 21740		
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Rose Hill Cemetery DATE: 5/16/98		20c. LOCATION — City or Town, State: Hagerstown MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Homar E. Watts		22. NAME AND ADDRESS OF FACILITY: Watsons Funeral Home 24 WBethel St. Hagerstown, MD. 21740		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. BRAIN TUMOR, METASTATIC, PRIMARY SITE UNKNOWN	1 WEEK
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: DEHYDRATION

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
NONE	M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Barry M. Cohen, MD	D01040	05-13-98

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BARRY M. COHEN, 18706 CRESTWOOD DR, HAGERSTOWN, MD, 21742

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAY 14 1998	Julia Davidson-Randall

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16315

Item:1 per M.D G-761 7/6/98 reb

Certificate of Death

Reg. No.

Margaret Duncan

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~Margret~~ MARGARET ~~Ducan~~ DUNCAN

2. Date of Death: Month May Day 9, Year 1998

3. Time of Death: 10:05 AM

4a. Facility Name (If not institution, give street and number): The Memorial Hospital

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 254-13-2736

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 4-3-1921

9. Birthplace (State or Foreign Country): GA.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md. 10b. County: B.BB 2474 Antony Terr

10c. City, Town or Location: 2474 Antony Terr Macon Ma.

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2474 Antony Terr

10f. Zip Code: 31201

10g. Citizen of What Country? U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOME MAKER

16b. Kind of Business/Industry: OWN Home

17. Father's Name (First, Middle, Last): Willie Joe Law

18. Mother's Name (First, Middle, Maiden Surname): 2474 Antony Ter Macon GA. Lenora Crawford

19a. Informant's Name/Relationship (Type, Print): Authur Duncan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2474 Antony Terr Macon GA.

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St Rest Cem

Date:

20c. Location - City or Town, State: Macon Ma.

21. Signature of Funeral Service Licensee: Ernest Dashiell

22. Name and Address of Facility: 322 East Aye. Easton Md. 21601 21601

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MASSIVE MYOCARDIAL INFARCTION — 1-2 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael J Fisher MD

29c. License number: D31867

29d. Date signed (Month, Day, Year): 5/9/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Michael J. Fisher - 511 Idlewild Ave., Easton, Md. 21601

State Registrar

31. Date filed (Month, Day, Year): MAY 11 1998

32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16316

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy Mae Fair
2. Date of Death Month Day Year: May 7, 1998
3. Time of Death: 9:55 AM
4a. Facility Name (If not institution, give street and number): Wilson Health Care Center
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 214-12-1274
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 8, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 301 Russell Avenue
10f. Zip Code: 20877
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Henry Offerman
18. Mother's Name (First, Middle, Maiden Surname): Anna Marie Piellusch

19a. Informant's Name/Relationship (Type, Print): John Raymond Fair/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7708 Camberford Place, Derwood, Maryland 20855

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park — Date: May 11, 1998
20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: Raymond Fair M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic Obstructive Pulmonary Disease — Dec

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Joel Schulman MD
29c. License number: D20516
29d. Date signed (Month, Day, Year): 5/7/98
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joel Schulman 9410 Old Georgetown Rd Bethesda MD 20814

State Registrar

31. Date filed (Month, Day, Year): MAY 11 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 16317

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Helen	Artemis	Fried	May 8,1998	3 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
9252 Three Oaks Drive	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-60-5314	1☐ M 2☒ F	71 Yrs.			Feb. 11,1927	India

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Montgomery	Silver Spring	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9252 Three Oaks Drive	20901	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	1	homemaker	own home

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
Vartan Costanian	Berjoohi Hacobian

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Audrey I. Fried/daughter	9252 Three Oaks Dr., Silver Spring, Md. 20901

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Parklawn Cemetery	May 12,98	Rockville, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	DeVol Funeral Home 2222 Wisconsin Ave.,N.W.,Washington,DC 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final diseese or condition resulting in death)	a. renal failure	1 week
	Due to (or es a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	b. non-hodgkin's lymphoma	11 years
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Piece of Death (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other (Specify)

27. Menner of Deeth	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how Injury occurred
1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piaca of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete end placa, and due to the cause(s) end menner es stated.
2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and pieca, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	DC20955	May 11,1998

30. Name and address of person who completed cause of deeth (item 23a) (Type, Print)
Stanley Frankel, M.D., 3800 Reservoir Rd.,N.W.,Washington,D.C. 20007-2197

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 13 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

JW

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16318

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Adene B. Freeman

2. Date of Death — Month: MAY Day: 8 Year: 1998

3. Time of Death: 1818

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 198-22-8139

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 69 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug 21, 1928

9. Birthplace *(State or Foreign Country)*: Waynesboro, Pa.

Usual Residence of Decedent

10a. State: Pa

10b. County: Franklin

10c. City, Town or Location: Waynesboro

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11512 Orchard Rd

10f. Zip Code: 17268

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Tour Guide

16b. Kind of Business/Industry: Bus Company.

17. Father's Name *(First, Middle, Last)*: Harry Nelson Zimmerman.

18. Mother's Name *(First, Middle, Maiden Surname)*: Jeannette. Miller.

19a. Informant's Name/Relationship *(Type, Print)*: James E Buffington / Son.

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11512 Orchard Rd Waynesboro Pa 17268

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Green Hill Cemetery — Date: 5/12

20c. Location - City or Town, State: Waynesboro Pa.

21. Signature of Funeral Service Licensee: James L Bowersox

22. Name and Address of Facility: Grove Funeral Home, Inc 505 Broad St Waynesboro Pa 17268

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. acute enterus wall myocardial infarction

Due to (or as a consequence of):
b. Pt wrestled in Field

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gary C Papachris

29c. License number: 032851

29d. Date signed *(Month, Day, Year)*: 5/8/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary C Papachris 1110 Medical Campus Rd Hagerstown MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 11 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

FREEMAN, ADENE B. #342941

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16319

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: James Edward Forsythe, Jr.
2. Dete of Deeth: Month: May; Dey: 7; Year: 1998
3. Time of Deeth: 2304
4e. Facility Name *(If not institution, give street and number)*: Washington County Hospital
4b. City, Town, or Location of Deeth: Hagerstown
4c. County of Deeth: Washington

Funeral Director

5. Sociel Security Number: 220-28-3951
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 64 Yrs.
If Under 1 Yeer: Months: ; Days:
If Under 24 Hrs.: Hours: ; Min.:
8. Dete of Birth *(Month, Dey, Yeer)*: Aug. 2, 1933
9. Birthplece *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Washington
10c. City, Town or Location: Williamsport
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 16729 Sterling Rd.
10f. Zip Code: 21795
10g. Citizen of Whet Country?: USA
11. Merital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No
If Yes, Give Yeer or Datas: 1953-1957
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Rece - Amerlcan Indien, Bleck, White, etc. Specify: White
15. Decedent's Educetion *(Specify only highest grede completed)*: Elementary/Secondery (0-12): 12; College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer
16b. Kind of Business/Industry: Construction
17. Fether's Neme *(First, Middle, Last)*: James Edward Forsythe, Sr.
18. Mother's Name *(First, Middle, Meiden Surneme)*: Virgie Irene Clipp Forsythe
19e. Informent's Neme/Reletionship *(Type, Print)*: Donna Forsythe / Wife
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 16729 Sterling Rd. Williamsport, Maryland 21795
20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Greenlawn Memorial Park
Dete: 5-11-98
20c. Location - City or Town, Stete: Williamsport, MD
21. Signeture of Funerel Service Licensee: [signature]
22. Neme end Address of Fecility: Osborne Funeral Home, 425 S. Conococheague St. Williamsport, MD 21795

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

James Edward Forsythe

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immedieta Ceuse (Finel disease or condition resulting in deeth)
e. CARDIOPULMONARY ARREST — 15 MINUTES
Due to (or as e consequence of):
b. PROBABLE PULMONARY EMBOLUS — 15 MINUTES
Due to (or es a consequence of):
c. INSULIN DEPENDANT DIABETES MELLITUS — YEARS
Due to (or es e consequence of):
d.

Sequentielly list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
PERIPHERAL VASCULAR DISEASE
RENAL FAILURE

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings evelleble prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*:
28b. Time of Injury: M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*:
28f. Location *(Street end Number or Rurel Route Number, City or Town, Steta)*:

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: [signature] PHYSICIAN
29c. Licensa number: D50950
29d. Dete signed *(Month, Dey, Yeer)*: 05-08-98

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Dr. D. Weinberg
SUITE 100, ROBINWOOD MEDICAL CENTER, 11110 MEDICAL CAMPUS ROAD, HAGERSTOWN

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: MAY 11 1998
32. Registrer's Signeture: Julia Davidson-Randese

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16320

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: IRMA LEE FRAMPTON
2. Date of Death Month: May Dey: 12 Year: 1998
3. Time of Death: 12:26AM
4a. Facility Name *(If not institution, give street and number)*: The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 217-12-4602
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 4, 1923
9. Birthplace *(State or Foreign Country)*: Easton, Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Talbot
10c. City, Town or Location: Tilghman
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 21486 Gibsontown Road
10f. Zip Code: 21671
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary
16b. Kind of Business/Industry: Public School/Education

17. Father's Name *(First, Middle, Last)*: Ralph H. Smith
18. Mother's Name *(First, Middle, Maiden Surname)*: Pauline Blake

19a. Informant's Name/Relationship *(Type, Print)*: R. Leslie Frampton/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O.Box 532, St. Michaels, Maryland 21663

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Woodlawn Memorial Park/May 15, 1998
20c. Location - City or Town, State: Easton, Maryland

21. Signature of Funeral Service Licensee: M. E. Newnam CFSP
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 200 S. Harrison Street, Easton, Maryland 21601

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Myocardial Infarction with Cardiogenic Shock — 8 hrs

Due to (or as a consequence of):
b. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thomas Fauntleroy Jr. 5-12-98
29c. License number: D15 315
29d. Date signed *(Month, Day, Year)*: 5-12-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thomas W. Fauntleroy, Jr., MD, 403 Marvel Court, Easton, MD 21601

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 13 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Steven Frampton
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend #8, 5/15/98,BMW,Montg.Co.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16321

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen J. Giffen

2. Date of Death: Month May, Day 12, Year 1998

3. Time of Death: 10:15am

4a. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 220-42-3157

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 12, ~~1998~~ 1906

9. Birthplace (State or Foreign Country): Ohio

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4802 Broad Brook Court

10f. Zip Code: 20814

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Organist

16b. Kind of Business/Industry: Funeral

17. Father's Name (First, Middle, Last): James Johnson

18. Mother's Name (First, Middle, Maiden Surname): Ida Sutton

19a. Informent's Name/Relationship (Type, Print): J. Robert Giffen (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2747 Winslow Lane Winston-Salem North Carolina 27103

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park

Date: May 15, 1998

20c. Location - City or Town, State: Rockville, Md.

21. Signature of Funeral Service Licensee: Curtis E. Day

22. Name and Address of Facility: DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877

Physician /Medical Examiner

BMW

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Emphysema — 10 Years

Due to (or as a consequence of):
b. Chronic Obstructive Pulmonary Disease — 10 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Myocardial Infarction — 11 Days

Due to (or as a consequence of):
d. Pneumonia — 11 Days

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia, Mild

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ylene A Larsen MD

29c. License number: D22599

29d. Date signed (Month, Day, Year): 5/12/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ylene A. Larsen MD 5454 Wisconsin Ave. Chevy Chase, Md. 20816

State Registrar

31. Date filed (Month, Day, Year): MAY 15 1998

32. Registrar's Signature: Julia Davidson-Randell

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Giffen, Helen 6476-1 5/13/98 10:05AM

12

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16322

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert C. Giffen

2. Date of Death: Month May Day 7 Year 1998

3. Time of Death: 7:15am

4e. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-05-3411

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 9, 1903

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Md.

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4802 Broad Brook Court

10f. Zip Code: 20814

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Pharmacist

16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): John M. Giffen

18. Mother's Name (First, Middle, Maiden Surname): Hazel Clark

19a. Informant's Name/Relationship (Type, Print): J. Robert Giffen (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2747 Winslow Lane Winston-Salem, N.C. 27103

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park

Date: May 11, 1998

20c. Location - City or Town, State: Rockville, Md.

21. Signature of Funeral Service Licensee: Curtis E. Day

22. Name and Address of Facility: DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Subarachnoid Hemorrage — 7 Days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ylene A Larsen MD

29c. License number: D22599

29d. Date signed (Month, Day, Year): 05-07-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ylene A. Larsen MD 5454 Wisconsin Ave Chevy Chase MD 20815

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ROBERT GIFFEN 5/7/98 7A

Division of Vital Records, P.O. Box 68760,

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State Registrar

31. Date filed (Month, Day, Year): MAY 11 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16323

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy Olive Gillespie
2. Date of Death (Month, Day, Year): May 12, 1998
3. Time of Death: 3:30 PM
4e. Facility Name *(If not institution, give street and number)*: 13108 Briarcliff Terr. #706
4b. City, Town, or Location of Death: Germantown
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 148-12-3561
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan 1, 1925
9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10e. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Germantown
10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13108 Briarcliff Terrace, #706
10f. Zip Code: 20874
10g. Citizen of What Country?: United States

11. Meritet Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Raca - American Indien, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Registered Nurse
16b. Kind of Business/Industry: Nursing

17. Father's Name *(First, Middle, Last)*: Martin J. O'Connor
18. Mother's Name *(First, Middle, Meiden Surneme)*: Mary Jane Lawless

19a. Informant's Name/Relationship *(Type, Print)*: Mark Gillespie, Son
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 20114 Timber Oak Lane, Germantown, MD 20874

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*:
20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: St. Gabriel's Cemetery
Dete: May 15, 1998
20c. Location - City or Town, Stete: Potomac, Maryland

21. Signature of Funeral Service Licensee: Gary M. [illegible]
22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Dr., Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): e. WIDELY METASTATIC BREAST CANCER — 1 YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequenca of):

c. Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physicten:** To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medicat Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end piece, end due to the cause(s) end menner steted.

29b. Signature end title of certifier: Mark R Abbruzzese MD
29c. License number: 15748
29d. Date signed *(Month, Day, Year)*: MAY 13, 1998

30. Name and eddress of person who completed cause of death (Item 23a) (Typa, Print): Dr. Mark R. Abbruzzese, M.D. - 4910 Mass. Ave., N.W., Washington, D.C. 20016

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 15 1998
32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16324

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
BLOOMAH	JACOBSON	GRANT	MAY	13,	1998	5:40 PM

4a. Facility Name (If not Institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
8100 CONNECTICUT AVE. #425	CHEVY CHASE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579 22 9224	1☐ M 2☒ F	90 Yrs.					JUNE 15,1907	ENGLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	MONTGOMERY	CHEVY CHASE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8100 CONNECTICUT AVE. #425	20815	UNITED STATES

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		LEGAL SECRETARY	LEGAL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
HENRY JACOBSON	TILLIE COHEN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ALAN GRANT (SON)	3208 WOODHOLLOW DR. CHEVY CHASE MD 20815

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	B'NAI ISRAEL CEMETERY	5/15/98	OXON HILL MD

21. Signature of Funeral Service Licensee: Robert Zansky

22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC 1170 ROCKVILLE PIKE, ROCKVILLE MD 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Myocardial Infarction	Sudden
Due to (or as a consequence of): b.	Coronary Artery Disease	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c.	Hypertension	years
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Joseph A Vassallo	M 21346	MAY 13, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph A. Vassallo MD., 5454 Wisconsin Ave., Chevy Chase, MD 20815

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 15 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16325

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Russell Lauren Green

2. Date of Death: Month: May Day: 11 Year: 1998

3. Time of Death: 8:55AM

4a. Facility Name (If not institution, give street and number): Fahrney-Keedy Memorial Home

4b. City, Town, or Location of Death: Boonsboro

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 220-01-4054

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 1, 1914

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 20 Richmond Terrace

10f. Zip Code: 21740

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: 41-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify: N

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Metal Worker

16b. Kind of Business/Industry: Fabricating

17. Father's Name (First, Middle, Last): Perry Green

18. Mother's Name (First, Middle, Maiden Surname): Cora Harrison

19a. Informant's Name/Relationship (Type, Print): Diana M. Shanholtz (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13928 Green Mountain Dr. Mauansville, Md. 21767

20a. Method of Disposition: ☒1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery

Date: May 14, 1998

20c. Location - City or Town, State: San Mar, Md.

21. Signature of Funeral Service Licensee: Dennis L. Davis

22. Name and Address of Facility: Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783

To Be Completed by Funeral Director

Russell L. Green

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Respiratory Failure — 1 day

Due to (or as a consequence of):

b. Pneumonia — 1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Probable Carcinoma Lung — 2 months

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D18019

29d. Date signed (Month, Day, Year): May 11, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Vasant Datta M.D. 334 Mill St. Hagerstown, Md. 21740

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Russell L. Green

State Registrar

31. Date filed (Month, Day, Year): MAY 14 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 98-6326

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John Willis Gittings, Jr.

2. Date of Death — Month: MAY; Day: 10; Year: 1998

3. Time of Death: 0400

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 217-92-2459

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 17, 1921

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1370 Marshall Street

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): None; College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: None

16b. Kind of Business/Industry: None

17. Father's Name *(First, Middle, Last)*: John Willis Gittings, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Myrtle Moberly

19a. Informant's Name/Relationship *(Type, Print)*: Sarah P. Miller

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1380 Marshall Street Hagerstown, Maryland 21740

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rest Haven Cemetery — Date: 5/12/98

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Gerald N. Minnich

22. Name and Address of Facility: Gerald N. Minnich Funeral Home, 305 N. Potomac Street Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Arrest Due to Aspiration — minutes

Due to (or as a consequence of):
b. Vomiting Due to Pyloric Spasm.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Mental Retardation

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: 20062 18727

29d. Date signed *(Month, Day, Year)*: 5/16/98 5/11/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): OCS & MD 370 Mill Street. Hagerstown Md 21740.

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 19 1998

32. Registrar's Signature: Gloria Davidson-Rondeau

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

GITTINGS, JOHN WILLIS JR.

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD

98-2641-017

GORDAN HENDERSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 11, per F.H. G-760 6/12/98 reb

Certificate of Death

Reg. No. 98 16327

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
GORDON THOMAS HENDERSON, SR.	MAY	09,	1998	7:22A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
CIVISTA MEDICAL CENTER	LAPLATA	CHARLES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-14-7137	XX 1 M 2 F	78 Yrs.					NOV. 10, 1919	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	CHARLES	MARBURY	1 ☐ Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
P.O.BOX 147	20658	UNITED STATES

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
XX 1 Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1944-1946	1 ☐ Yes 2 XX No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	MACHINIST	U.S. GOVERNMENT

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
VICTOR FAIRCHILD HENDERSON	EDITH ROWE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RUTH E. HENDERSON - WIFE	P.O.BOX 147, MARBURY, MARYLAND 20658

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
XX 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	TRINITY MEM. GARDENS,	MAY 14, 1998,	WALDORF, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
MGB Mark G. Brohawn M00053	THE HUNTT FUNERAL HOME, INC. P.O.BOX 156, WALDORF, MARYLAND 20604

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, euch es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximeta Interval Between Onsel and Deeth

Immediate Cause (Final disease or condition resulting in daath)
a. Atherosclerotic Cardiovascular Disease

Dua to (or as a consequance of):

Sequentially list condiilons, if any, leading to immediata cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last
b.

Dua to (or as a consaquence of):
c.

Due to (or as a consequenca of):
d.

Part ii. **Other significant conditione** contributing to death bul not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of daath?
1 ☐ Yes 2 X No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only ona)	
XX 1 Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 ☐ Accidant 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28a. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☐ **Certifying Phyeician:** To the best of my knowledga, death occurrad at the tima, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examination and/or invastigation, in my opinion, death occurred ei the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E.	MAY 10,1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 15 1998	Julia Strickler Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16328

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDNA EARL HEADLEY
2. Date of Death Month Day Year: MAY 12, 1998
3. Time of Death: 1:30 AM
4a. Facility Name (If not institution, give street and number): CHARLES COUNTY NURSING & REHAB CENTER
4b. City, Town, or Location of Death: LA PLATA
4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 226-20-9883
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Yaer: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JANUARY 15, 1909
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CHARLES
10c. City, Town or Location: INDIAN HEAD
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 55 ELDER PLACE
10f. Zip Code: 20640
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 6
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER
16b. Kind of Business/Industry: CHARLES COUNTY BOARD OF EDUCATION

17. Father's Name (First, Middle, Last): JOHN HENRY EDWARDS
18. Mother's Name (First, Middle, Maiden Surname): MAUDE BOOTH

19a. Informant's Name/Relationship (Type, Print): JAMES E. HEADLEY, SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6394 NELSON DRIVE, LA PLATA, MD 20646

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): TRINITY MEMORIAL GARDENS
Date: 5/15/1998
20c. Location - City or Town, State: WALDORF, MARYLAND

21. Signature of Funeral Service Licensee: JPK Mark G. Brohawn MARK G. BROHAWN M00053
22. Name and Address of Facility: THE HUNTT FUNERAL HOME, INC. P.O.BOX 156, WALDORF, MARYLAND 20604

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pleural Effusions	Weeks
Due to (or as a consequence of): b.	Anasarca	Weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Hypoalbuminemia	Months
Due to (or as a consequence of): d.	Malnutrition	Months

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Recent Hip fracture. (L)

Recent (R) Humeral Fracture

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D46419
29d. Date signed (Month, Day, Year): 5/12/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charlene A. Letchford MD 404 E Charles St La Plata MD 20646

State Registrar

31. Date filed (Month, Day, Year): MAY 15 1998
32. Registrar's Signature: Julia Davidson Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Headley, Edna Edwards

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16329

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Richard Atherton Humphrey	May 8, 1998	7:54 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
7902 Kentbury Drive	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
011-14-0181	1☒M 2☐F	83 Yrs.					Sept. 16, 1914	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Bethesda	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7902 Kentbury Drive	20814	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
	5+	Educator	Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Carl T. Humphrey	Helen Richards

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Elisabeth C. Humphrey/Wife	7902 Kentbury Drive, Bethesda, Maryland 20814

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Montgomery Crematorium, Inc.	May 10, 1998	Bethesda, Maryland

21. Signature of Funeral Service Licensee		22. Name and Address of Facility
Randy Faulk	M00198	Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac Arrest	
	Due to (or as a consequence of):	
	Chronic Obstructive Pulmonary Disase	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	Prostate Cancer	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D26259	5/8/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ava A. Kaufman, M.D. 4930 Del Ray Avenue, Bethesda, Maryland 20814

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 11 1998	Julie Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16330

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BRYCE DAVID HANNA

2. Data of Death: Month May Day 12 Year 1998

3. Time of Death: 12:16

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: N/A

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 0 Yrs. If Under 1 Year: Months Days If Under 24 Hrs.: Hours 1 Min. 16

8. Data of Birth (Month, Day, Year): May 12, 1998

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 11003 Eastwood Drive

10f. Zip Code: 21740

10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0 College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A

16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): David Eugene Hanna

18. Mother's Name (First, Middle, Maiden Surname): Diana Lynn Burnett

19a. Informant's Name/Relationship (Type, Print): David Eugene Hanna, Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11003 Eastwood Drive, Hagerstown, Maryland 21740

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Lawn Memorial Park

Date: May 16

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Kelly A Younker

22. Name and Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N., Hagerstown, Maryland 21742

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):

a. PREMATURITY (27 WEEK GESTATION)

Due to (or as a consequence of):

b. PERINATAL ASPHYXIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Douglas Becker

29c. License number: D29822

29d. Date signed (Month, Day, Year): 05/15/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Becker 324 E ANTIETAM STREET Hagerstown Maryland

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Bryce David Hanna

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAY 18 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16331

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marion L. Heard
2. Date of Death (Month, Day, Year): May 8, 1998
3. Time of Death: 1:55 PM
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 374-18-5189
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 26, 1917
9. Birthplace (State or Foreign Country): Mississippi

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 13200 Tamarack Road
10f. Zip Code: 20904
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+): 5
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Counselor
16b. Kind of Business/Industry: D.C. Public Schools

17. Father's Name (First, Middle, Last): Beverly Heard
18. Mother's Name (First, Middle, Maiden Surname): Marion Hill

19a. Informant's Name/Relationship (Type, Print): Gloria E. Heard (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13200 Tamarack Road, Silver Spring, MD 20904

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lincoln Memorial Cemetery
Date: 5/14/98
20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: Lynne McGuire
22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

BW

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Cardio pulmonary arrest
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Aspiration pneumonia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Parkinson's Advanced colonmy atory disease.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D52191
29d. Date signed (Month, Day, Year): 5/8/98
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ESTEBAN MARQUEZ 2101 EAST JEFFERSON ST. Rockville MD 20849

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

State Registrar

31. Date filed (Month, Day, Year): MAY 12 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 16332

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN JOSEPH HANRAHAN

2. Date of Death: Month MAY Day 9 Year 1998

3. Time of Death: 1:20 PM

4a. Facility Name (If not institution, give street and number): BROOKE GROVE NURSING AND REHABILITATION CENTER

4b. City, Town, or Location of Death: SANDY SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 232-10-2483

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): Feb. 3, 1917

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 14626 Deerhurst Terrace

10f. Zip Code: 20906

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yas, Give Yaar or Dates: 1945-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: Postal Service

17. Father's Name (First, Middle, Last): Thomas Hanrahan

18. Mother's Neme (First, Middle, Melden Sumama): Emma Doyle

19e. Informent's Name/Relationship (Type, Print): Dorothy Murphy (P.O.A.)

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 14626 Deerhurst Terrace, Silver Spring, MD 20906

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cametery, crematory or other placa): Gate of Heaven Cemetery

Date: 5/12/98

20c. Location - City or Town, Stata: Silver Spring, MD

21. Signature of Funeral Service Licensee: Andrew J. Cole

22. Nama and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter tha disease, or complications that caused the daath. Do not enter tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only one cause on aach line.

Approximata Intarval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. VENTRICULAR ARRHYTHMIA — MINUTES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

b. ELECTROLYTE DISTURBANCE — HOURS

Due to (or as a consequence of):

c. DEHYDRATION — DAYS

Due to (or as a consequence of):

d. SMALL BOWEL OBSTRUCTION — DAYS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CEREBROVASCULAR ACCIDENT

ATHEROSCLEROTIC HEART DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(a) end manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: STAFF PHYSICIAN

29c. Licansa number: D42046

29d. Data signed (Month, Day, Year): MAY 9, 1998

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): GRACE BROOKE HUFFMAN, MD 18100 SLADE SCHOOL ROAD SANDY SPRING MARYLAND 20860

State Registrar

31. Date filed (Month, Day, Year): MAY 11 1998

32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

98 16333

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JANE L. HANSBOROUGH
2. Date of Death Month: MAY Day: 09 Year: 98
3. Time of Death: 2129
4a. Facility Name *(If not Institution, give street and number)*: MONTGOMERY GENERAL HOSPITAL
4b. City, Town, or Location of Death: OLNEY
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-26-2890
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Yaer)*: Jan. 8, 1924
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 15320 Pine Orchard Drive, 3H
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Nama *(First, Middle, Last)*: James Andrew Webster
18. Mother's Name *(First, Middle, Maiden Sumame)*: Pearl Degges

19a. Informent's Neme/Reletionship *(Type, Print)*: Russell Hansborough (husband)
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)* 20906: 15320 Pine Orchard Drive, 3H, Silver Spring, MD

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Pleca of Disposition *(Name of cemetery, crematory or other placa)*: Gate of Heaven Cemetery | Date: 5/13/98
20c. Location - City or Town, Stete: Silver Spring, MD 20901

21. Signature of Funeral Service Licensee: Steven D Stencil
22. Neme and Addrass of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or compliceting thet caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immedlete Ceuse (Finel disease or condition resulting in death)
e. VENTRICULAR FIBRILLATION — 3 MIN

Due to (or es a consequenca of):
b. HYPOVOLEMIC SHOCK

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury thet initieted events rasulting in death) Last
Due to (or as a consequence of):
c. RUPTURED AORTIC ANEURYSM

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☒ Yes 2☐ No
26. Piece of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and menner as stated. 2☒ **Medicel Examiner:** On the besis of examination and/or investigetion, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and manner steted.
29b. Signature and title of certifier: M.D. DEPUTY MEDICAL EX.
29c. Licansa number: 015236
29d. Dete signed *(Month, Day, Year)*: MAY 09, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARL I. MARGOLIS, MD 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 11 1998
32. Registar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16334

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HENRY N. HAUPA
2. Date of Death Month: MAY Day: 5 Year: 1998
3. Time of Death: 11:20 PM
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-05-4141
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 1, 1916
9. Birthplace (State or Foreign Country): Wash. DC

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 812 Gist Ave
10f. Zip Code: 20910
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [XX] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [XX] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plumber
16b. Kind of Business/Industry: Plumbing Company

17. Father's Name (First, Middle, Last): Henry A. Haupa
18. Mother's Name (First, Middle, Maiden Surname): Alma

19a. Informant's Name/Relationship (Type, Print): John R. Hinze (Personal Rep.)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 76 Long Creek Drive Stevensville, Md. 21666

20a. Method of Disposition: 1 [ ] Burial 2 [XX] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory — Date: 5/10/1998
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Donald V. Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Pulmonary Embolism — Approximate Interval Between Onset and Death: days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jeanne P. Asher MD
29c. License number: D34032
29d. Date signed (Month, Day, Year): 5/7/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JEANNE P. ASHER, MD, 3720 FARRAGUT AVE KENSINGTON MD 20895

State Registrar

31. Date filed (Month, Day, Year): MAY 11 1998
32. Registrar's Signature: Gloria Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

98-6335

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Catherine Jackson

2. Date of Death — Month: May; Day: 04; Year: 1998

3. Time of Death: 2215

4e. Facility Name *(If not institution, give street and number)*: The Kent & Queen Anne's Hospital Inc.

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 220-32-9684

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 28, 1922

9. Birthplace *(State or Foreign Country)*: Millington, MD

Usual Residence of Decedent

10a. State: Maryland

10b. County: Queen Anne's

10c. City, Town or Location: Sudlersville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 825 Stulltown Road

10f. Zip Code: 21668

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 7th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: ownhome

17. Father's Name *(First, Middle, Last)*: Frank Embert

18. Mother's Name *(First, Middle, Meiden Surname)*: Lola Mae Alexander

19a. Informent's Neme/Relationship *(Type, Print)*: Williard Jackson, Sr./Husband

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 825 Stulltown Road, Sudlersville, MD 21668

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, crematory or other place)*: Sudlersville Cemetery/May 8, 1998

20c. Location - City or Town, State: Sudlersville, MD

21. Signature of Funeral Service Licensee: Gary B. Fellows

22. Name and Address of Facility: Fellows, Helfenbein, & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Cardio Resp Arrest. — 30 min

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Lest

b. ASCVD; Afib

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Right Arm Thrombophlebitis; Stage 3C Ovarian Carcinomatosis, Non Healing Abd. Wound. 2° to Surgery Debulking Cancer HH GERD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)* — Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☒ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)* — 1☒ **Certifying Phyalcian:** To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, dete and piece, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Neil Stoddard MD

29c. License number: D50996

29d. Date signed *(Month, Day, Year)*: 5/5/98

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): Dr. Neil Stoddard 100 Brown Street, Chestertown, MD 21620

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

12

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 07 '98

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16336

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CATHERINE VICTORIA WILLS JONES
2. Date of Death (Month, Day, Year): May 14, 1998
3. Time of Death: 1:15AM
4a. Facility Name (If not institution, give street and number): Civista Medical Center
4b. City, Town, or Location of Death: La Plata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 214-28-9688
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 14, 1918
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CHARLES
10c. City, Town or Location: LA PLATA
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7754 CRAIN HIGHWAY
10f. Zip Code: 20646
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE
16b. Kind of Business/Industry: HOMEMAKER

17. Father's Name (First, Middle, Last): ROBERT DYSON
18. Mother's Name (First, Middle, Maiden Surname): ANNIE MILLS DYSON

19a. Informant's Name/Relationship (Type, Print): AUDREY WILLS / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3707 WILKINSON DRIVE SUITLAND, MARYLAND 20746

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SACRED HEART CHURCH CEM.
Date: 5/18/98
20c. Location - City or Town, State: LA PLATA, MARYLAND

21. Signature of Funeral Service Licensee: Lydia C. Thornton Johnson
LYDIA C. THORNTON JOHNSON
22. Name and Address of Facility: THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD INDIAN HEAD, MD 20640

Physician /Medical Examiner

23a. Part1. Enter the diseesa, or complicetions thet caused the deeth. Do not entar the mode of dying, such es cardiac or respiretory errest, shock, or haart failure. List only one ceuse on aech lina.

Approximeta Interval Between Onset and Deeth

Immediete Ceuse (Finel disaasa or condition resulting in deeth):
e. Hypoxemia due to pneumonia VS CHF

Due to (or es e consequence ot):
b. Pancreatic mass

Sequentially list conditions, if any, leeding to immediata causa. Enter Underlying Cause (Diseesa or Injury thet Initieted evants resulting in deeth) Last

Due to (or es e consequenca of):
c. Renal failure.

Due to (or es e consequenca of):
d. cardiomyopathy.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings availeble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Plece of Death (Check only ona): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the tima, deta and placa, and due to the ceuse(s) end menner stated.

29b. Signature end title of certifier
29c. Licanse number: D-45737
29d. Dete signed (Month, Dey, Year): 5/14/98

30. Neme end eddrass of person who completed causa of daeth (Item 23a) (Type, Print): Nirmaladevi Gurusamy,MD 6 Post Office Road Suite 103 Waldorf,Maryland 20602

State Registrar

31. Dete filed (Month, Dey, Year): MAY 15 1998
32. Registrer's Signetura: Julia Strickson-Randall

DHMH 16 Rev 6/95

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Catherine Victoria Jones

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16337

Item: 27 per MEO G-760 6/15/98 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret L. Jacobs
2. Date of Death Month: May Day: 8, Year: 1998
3. Time of Death: 3:30 PM
4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-20-0223
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 15, 1923
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Takoma Park
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7215 15th Avenue
10f. Zip Code: 20912
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Clarence A. Parezo
18. Mother's Name *(First, Middle, Maiden Surname)*: Edith M. Kopp

19a. Informant's Name/Relationship *(Type, Print)*: Linda Gatton (daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7232 15th Avenue, Takoma Park, MD 20912

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MD Veterans Cemetery — Date: 5/12/98
20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: James E. Dooley
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. PNEUMONIA — 1 WEEKS

Due to (or as a consequence of):
b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS
HIP FRACTURE

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*: 04/24/98
28b. Time of Injury: NOT KNOWN M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how Injury occurred: FALL.
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: RESIDENCE
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: RESIDENCE

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: 015236
29d. Date signed *(Month, Day, Year)*: MAY 09, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARL I. MARGOLIS, M.D. 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 11 1998
32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16338

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jaime A. Jarrin

2. Date of Death — Month: May; Day: 7; Year: 1998

3. Time of Death: 5:00AM

4a. Facility Name *(If not institution, give street and number)*: 10804 East Nolcrest Drive

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-62-8856

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: Feb.8, 1914

9. Birthplace *(State or Foreign Country)*: Ecuador

Usual Residence of Decedent

10e. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 10804 East Nolcrest Drive

10f. Zip Code: 20903

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [X] Yes 2 [ ] No *Specify:* Ecuadorian

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Administrator

16b. Kind of Business/Industry: Administrative

17. Father's Name *(First, Middle, Last)*: Victor Jarrin

18. Mother's Name *(First, Middle, Maiden Surname)*: Judith Ayala

19a. Informant's Name/Relationship *(Type, Print)*: Raquel I. Jarrin (wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10804 East Nolcrest Drive Silver Spring, Maryland 20903

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: 05/11/98

20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: Martha Pickl

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Pancreatic Carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Obstructive Jaundice

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: MD 000013853

29d. Date signed *(Month, Day, Year)*: 5/7/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Margarita E. Nazdin, 1140 Varnum St, NE, Washington, DC 20017-2151

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 13 1998

32. Registrar's Signature: Julia Davidson-Randell

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16339

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month Day Yaer	3. Tima of Death
Robert Theodore Jenson	May 14, 1998	2:00 AM

4a. Facility Nama (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Suburban Hospital	Bethesda	Montgomery

Funeral Director

5. Social Sacurity Numbar	6. Sax	7. Aga (In yrs. last birthday)	If Undar 1 Yaar: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplaca (State or Foreign Country)
480-16-1089	1☒ M 2☐ F	79 Yrs.			Aug. 4, 1918	Iowa

Usual Rasidance of Dacedant

10a. Steta	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Bethesda	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
6012 Cairn Terrace	20817	United States

11. Maritel Stetus	12. Was Decedant Evar in U.S. Armed Forcas?	13. Was Dacedant of Hispenic Origin? (Spacify Yes or No- If Yas, specify Cuban, Maxicen, Puerto Rican, atc.)	14. Rece - Amarican Indian, Black, White, atc.
1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☒ Yas 2☐ No If Yas, Give Year or Datas: WW II	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedant's Education (Specify only highast grada complatad)		16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired)	16b. Kind of Businass/Industry
Elamantary/Secondary (0-12)	College (1-4or 5+)		
12	2	Real Estate Investor	Self-employed

17. Fathar's Nama (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Theodore E. Jenson	Annette M. Anderson

19a. Informant's Nama/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code)
Paula Rae Jenson (daughter)	Same as 10

20a. Mathod of Disposition	20b. Place of Disposition (Nama of cematary, crematory or othar place)	Data	20c. Location - City or Town, Stata
1☐ Burial 2☒ Cremation 3☐ Ramoval from Steta 4☐ Donation 5☐ Othar (Specify)	Chesapeake Crematory	5-15-98	Beltsville, Maryland

21. Signeture of Funaral Service Licensee	22. Nama and Addrass of Facility
▶ Ellen N. Rapp	Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Entar the disaasa, or complications that caused the daath. Do not enter tha moda of dying, such es cardiac or raspiratory arrast, shock, or haart failure. List only ona cause on aach lina.

Approximate Intervel Between Onset and Deeth

Immediete Ceuse (Final disaase or condition resulting in daath)	a. Broncepneumonia	days
	Dua to (or as a consequance of):	
Sequantially list conditions, if any, laading to immediata causa. Entar Underlying Causa (Disaasa or injury that initiated avants resulting in daath) Last	b.	
	Dua to (or as a consequance of):	
	c.	
	Dua to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to daath but not resulting in tha underlying causa givan in Part I.

Renal Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad?	24b. Wara autopsy findings available prior to completion of ceuse of death?
1☐ Yas 2☒ No	1☐ Yes 2☒ No

25. Was cesa rafarred to medicel examinar?	26. Piece of Deeth (Check only ona)	
1☐ Yas 2☑ No	Hospital: 1☑ Inpatiant 2☐ ER/Outpatiant 3☐ DOA	Othar: 4☐ Nursing Homa 5☐ Rasidence 6☐ Other (Specify)

27. Mannar of Deeth	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Panding invastigation 6☐ Could not ba datarmined		M	1☐ Yas 2☐ No	
	28a. Place of Injury - At home, farm, straat, factory, offica building, atc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To tha bast of my knowladga, daath occurred at tha time, dete end place, and dua to the cause(s) and mannar es steted.
2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, daeth occurred at tha tima, data and place, and dua to tha cause(s) and mannar steted.

29b. Signature and title of certifier	29c. License numbar	29d. Data signad (Month, Day, Yaar)
▶	D33357	5/14/98

30. Nama and eddrass of person who completed cause of death (Item 23a) (Typa, Print) 20815

Lee Jonathan Musher MD 5530 Wisconsin Ave Chevy Chase MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Robert T. Jenson May 14 1998 2P

Division of Vital Records, P.O. Box 68760,

10

State Registrar

31. Data filad (Month, Day, Yaar)	32. Registrar's Signature
MAY 15 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16340

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Linwood Hill Johnson, Jr.

2. Date of Death Month Day Year: May 13, 1998

3. Time of Death: 5:30 AM

4a. Facility Name *(If not institution, give street and number)*: 10705 Pebblebrook Lane

4b. City, Town, or Location of Death: Potomac

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 046-16-1215

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: January 24, 1919

9. Birthplace *(State or Foreign Country)*: Maine

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Potomac

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 10705 Pebble Brook Lane

10f. Zip Code: 20854

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: World War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Physician

16b. Kind of Business/Industry: General Surgery

17. Father's Name *(First, Middle, Last)*: Linwood Hill Johnson, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Emma A. DePatie

19a. Informant's Name/Relationship *(Type, Print)*: Alma Burton Johnson/wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10705 Pebble Brook Lane, Potomac, Maryland 20854

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Parklawn Memorial Park | Date: May 15, 1998

20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: Barbara J. McMullen Lawrence M00831

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
- e. Acute Myocardial Infarction — 10 minutes

Due to (or as a consequence of):
- b. Coronary Atherosclerosis — 20 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
- c. Generalized Atherosclerosis — 30 years

Due to (or as a consequence of):
- d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph Connor, M.D.

29c. License number: D02045

29d. Date signed *(Month, Day, Year)*: May 13, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Joseph Connor, M.D. 6000 Executive Blvd., #300, Rockville, Maryland 20852-2802

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 14 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

98-2566-031
CMK
TERRITA V. JONES

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16341

Items: 23 part I,27 per MEO G-760 6/10/98 rev

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
TERRITA V. JONES	MAY 06, 1998	0829AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HOLY CROSS HOSPITAL	SILVER SPRING	MONTGOMERY COUNTY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-25-2547	1☐M 2☒F	8 Yrs.					Nov. 1,1989	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Silver Spring	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1814 Cody Drive	20902	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
3rd		Student	Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Rosevelt Jones	Lori A. Doye

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lori A. Doye (Mother)	1814 Cody Drive, Silver Spring, MD 20902

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Ash Memorial Cem.	5/12/98	Sandy Spring, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
George R. Snowden	SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a. SEIZURE DISORDER AND LEUKODYSTROPHY	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Wes en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☑Yes 2☐No	1☑Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospitel: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
☒1 Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and menner es steted.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Marjorie Bruhl	O.C.M.E.	MAY 07, 1998

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)
MARJORIE A. BRUHL M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 13 1998	Julia Davidson-Randell

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16342

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Patricia Hagan Kane
2. Date of Death Month Day Year: May 13, 1998
3. Time of Death: 6:00PM
4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-52-4110
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 7, 1935
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9923 Brixton Lane
10f. Zip Code: 20817
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Thomas Leroy Hagan
18. Mother's Name *(First, Middle, Maiden Surname)*: Helen Leonard

19a. Informant's Name/Relationship *(Type, Print)*: Matthew A. Kane (husband)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9923 Brixton Lane, Bethesda, MD 20817

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery
Date: 5/18/98
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Andrew J. Cole
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

BMW

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Acute myocardial infarction

Due to (or as a consequence of):
b. Coronary atherosclerosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Diabetes, type I

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetic neuropathy

Diabetic nephropathy

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H. Robert Birschbach, Jr. M.D.
29c. License number
29d. Date signed *(Month, Day, Year)*: May 13, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H. Robert Birschbach, 6320 Democracy Blvd. Bethesda, MD 20817

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 15 1998
32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16343

Certificate of Death

Reg. No.

Physician-/Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Henri George Kling

2. Date of Death (Month, Day, Year): May 7, 1998

3. Time of Death: 9:00AM

4a. Facility Name *(If not institution, give street and number)*: 6015 Onondaga Road

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-03-0773

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: May 1, 1904

9. Birthplace *(State or Foreign Country)*: France

Usual Residence of Decedent

10e. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6015 Onondaga Road

10f. Zip Code: 20816

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Hair Dresser

16b. Kind of Business/Industry: Self-Employed/ Hair Salon

17. Father's Name *(First, Middle, Last)*: Joseph Kling

18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Lang

19a. Informent's Name/Relationship *(Type, Print)*: Michael M. Kling/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8940 Bradmoor Drive, Bethesda, Maryland 20817

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Montgomery Crematorium, Inc. Date: May 8, 1998

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: ▶ Daniel E. Perry. M00803

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Deeth

Immediate Ceuse (Final disaase or condition resulting in death)
e. Renal Failure — 12 Months

Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last
b. Diabetes Mellitus — 35 Years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dry Gangrene

Generalized Arteriosclerosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availebie prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only ona)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residenca 8☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D10205

29d. Date signed *(Month, Dey, Year)*: May 7, 1998

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Stanley M. Silverberg, M.D. 5454 Wisconsin Avenue, #925, Chevy Chase, MD 20815

State Registrar

31. Data filed *(Month, Dey, Year)*: MAY 11 1998

32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16344

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PAUL LEROY KNIGHT
2. Date of Death (Month, Dey, Year): MAY 10 1998
3. Time of Death: 3:40 PM
4a. Facility Name *(If not institution, give street and number)*: NATIONAL NAVAL MEDICAL CENTER
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 304 38 5994
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: February 3, 1939
9. Birthplace *(State or Foreign Country)*: Indiana

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Locetion: Rockville
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street end Number: 5129 Norbeck Road
10f. Zip Code: 20853
10g. Citizen of Whet Country?: USA
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: 1957 - 1988
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Reca - American Indian, Black, White, etc. *Specify:* White
15. Decedent'e Education *(Specify only highest grade completed)*: Elemantary/Secondary (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usuel Occupetion *(Giva kind of work done during most of working life. DO NOT use retired)*: Commander
16b. Kind of Business/Industry: US Navy
17. Fether's Neme *(First, Middle, Last)*: Harold Knight
18. Mother's Name *(First, Middle, Maiden Surname)*: Eva Yoder
19a. Informent's Name/Relationship *(Type, Print)*: Julie N. Knight /wife
19b. Mailing Addrass *(Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Code)*: 5129 Norbeck Road, Rockville, Maryland 20853
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Arlington National Cemetery | Data: 5/27/98
20c. Location - City or Town, State: Arlington, Virginia
21. Signeture of Funerel Service Licensea: ▶ [signature]
22. Neme and Address of Facility: Lee Funeral Home of Manassas 8521 Sudley Road, Manassas, Virginia 20109

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only ona causa on aach lina.

Approximete Interval Between Onsat end Death

Immedlete Ceuse (Finel diseese or condition resulting in deeth): e. METASTATIC RENAL CELL CARCINOMA

Dua to (or es a consaquance of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in daath) Last

b. Due to (or es e consequence of):

c. Due to (or es a consequenca of):

d.

Part II. **Other eignificant conditions** contributing to death but not resulting in tha underlying cause givan in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings eveileble prior to completion of cause of daath? 1☐ Yes 2☐ No

25. Was cesa raferred to medical exeminar? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only ona)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA | Othar: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, deeth occurred et tha time, dete end plece, end due to tha cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or Investigation, in my opinion, daath occurred at tha tima, data end place, and dua to tha causa(s) end manner stated.

29b. Signature end title of certifier: ▶ [signature]
29c. License number: D-51503
29d. Dete signed *(Month, Day, Year)*: 11 May 98

30. Nama and address of person who complated causa of daath (Item 23a) (Type, Print): D.L.BLAZES, LT, MC, USN
NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 15 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16345

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edmund John Peter Krygier
2. Date of Death Month Day Year: May 12, 1998
3. Time of Death: 6:50 PM
4a. Facility Name *(If not institution, give street and number)*: 90 Monroe Street, #302
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 323-22-4494
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 27, 1929
9. Birthplace *(State or Foreign Country)*: Illinois

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 90 Monroe Street, #302
10f. Zip Code: 20850
10g. Citizen of What Country?: United States
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No
If Yes, Give Year or Dates: 1951-1955
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Senior Vice President of Data Operations
16b. Kind of Business/Industry: Bank
17. Father's Name *(First, Middle, Last)*: Edmund Krygier, Sr.
18. Mother's Name *(First, Middle, Meiden Surname)*: Helen Mikulski
19a. Informant's Name/Relationship *(Type, Print)*: Katherine A. Krygier/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7908 Pearlbush Drive, #104, Gaithersburg, MD 20879
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc.
Date: May 15, 1998
20c. Location - City or Town, State: Bethesda, Maryland
21. Signature of Funeral Service Licensee: David E. Dery M00803
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in death)
a. Myocardial Infarction — Sudden

Due to (or as a consequence of):
b. Diabetes — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequenca of):
c. Hypercholestremia — Years

Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diarrhea

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [X] Residenca 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John R. Melnick M.D.
29c. Licansa number: D19294
29d. Data signad *(Month, Day, Year)*: May 13, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John R. Melnick, M.D. 911 Russell Avenue, Gaithersburg, Maryland 20879

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 14 1998
32. Registrar's Signature: Julia Davidson-Randell

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

JW

9+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16346

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Dorothy M. Kruzel	May 6, 1998	3:30 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Shady Grove Adventist Hospital	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
199-22-2531	1☐M 2☒F	69 Yrs.			April 8, 1929	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Montgomery Village	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9836 Canal Road	20886	United States

11. Marital Status	12. Was Decedent Ever In U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemeker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Peter Jastrzebski	Kathryn Wychock

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William Kruzel, Husband	9836 Canal Road, Montgomery Village, MD 20886

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Gate of Heaven Cemetery	May 9, 1998	Silver Spring, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	DeVol Funeral Home 10 E. Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Ceuse (Final diseese or condition resulting in death)	a. multple organ failure	3years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet Initieted events resulting in death) Last	b. Metastatic endometrial cancer	
	Due to (or es e consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yee 2☒No 3☐Probably 4☐Unknown

24a. Wes an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Piece of Deeth (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residenca 8☐Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner.** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end pleca, and due to the cause(s) end menner steted.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
▶ [signature]	D38682	MAY 6 1998

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print)

Albert J. Steren, M.D., 9715 Medical Center Drive, #436 Rockville, MD 20850

State Registrar

31. Dete filed (Month, Day, Yeer)	32. Registrar's Signature
MAY 11 1998	▶ [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16347

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: JOSEPH NICHOLAS KOLB

2. Dete of Death Month: May Dey: 8 Yeer: 1998

3. Time of Death: 19:45

4e. Feciity Neme *(If not Institution, give street end number)*: WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Deeth: HAGERSTOWN

4c. County of Death: WASHINGTON

Funeral Director

5. Sociel Security Number: 216-07-3891

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. lest birthday)*: 82 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: 08/02/1915

9. Birthpiece *(Stete or Foreign Country)*: MARYLAND

Usuel Residence of Decedent

10e. Stete: MARYLAND

10b. County: WASHINGTON

10c. City, Town or Location: HAGERSTOWN

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 13901 PONTIUS LANE

10f. Zip Code: 21740

10g. Citizen of Whet Country?: U.S.A.

11. Marital Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 8 YEARS — College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: TRUCK DRIVER

16b. Kind of Business/Industry: OIL SALES COMPANY

17. Fether's Neme *(First, Middle, Last)*: NICHOLAS KOLB

18. Mother's Neme *(First, Middle, Maiden Surneme)*: ALICE HASTINGS

19e. Informent's Neme/Reletionship *(Type, Print)*: JOANNE V. SHANK/DAUGHTER

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 13901 PONTIUS LANE, HAGERSTOWN, MD 21740

20e. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Pleca of Disposition *(Neme of cemetery, cremetory or other placa)*: SMITHSBURG CREMATORY — Dete: 05/09/98

20c. Location - City or Town, Stete: SMITHSBURG, MARYLAND

21. Signeture of Funerel Servica Licensee: P. Steven Danfelt, Jr. — P. STEVEN DANFELT, JR.

22. Name end Address of Feciility: BAST FUNERAL HOME — 7606 OLD NATIONAL PIKE BOONSBORO, MARYLAND 21713

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximete Intervel Between Onset end Death

Immedlete Ceuse (Finel diseese or condition resulting in deeth)
e. Pneumonia — 3-4 days

Due to (or es e consequence of):
Chronic obstructive Pulmonary Disease — yrs

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest
b.

Due to (or es e consequence of):
c.

Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.
Cerebrovascular Accident Dysphagia
Polycythemia Vera, Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☐ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medicel exeminer? 1☐ Yes 2☐ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)* — 28b. Time of Injury — M — 28c. Injury et Work? 1☐ Yes 2☐ No — 28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)* — 28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☐ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: MD

29c. License number: D 18019

29d. Dete signed *(Month, Dey, Yeer)*: May 9, 1998

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): Dr Datta 334 Mill Street Hagerstown, Maryland

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Joseph Nicholas Kolb

State Registrar

31. Dete filed *(Month, Day, Yeer)*: MAY 11 1998

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16348

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PAULINE JONES KINLOCK

2. Data of Death — Month: MAY Day: 10 Year: 1998

3. Time of Death: 9:10 PM

4a. Facility Name (If not institution, giva street and number): SHORE NURSING & REHABILITATION CTR.

4b. City, Town, or Location of Death: DENTON

4c. County of Death: CAROLINE

Funeral Director

5. Social Security Number: 215-32-2404

6. Sax: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 91 Yrs.

If Under 1 Yaar — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Data of Birth (Month, Day, Year): August 27, 1906

9. Birthplaca (Stata or Foreign Country): Talbot County

Usual Residence of Decedent

10a. State: Maryland

10b. County: Talbot

10c. City, Town or Location: Easton

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 29353 Woodbridge Drive

10f. Zip Code: 21601

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Raca - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+):

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Education Nursery & Kindergarten

17. Father's Name (First, Middle, Last): Alfred T. Jones

18. Mother's Name (First, Middle, Maidan Surnama): Hattie Helsby

19a. Informant's Name/Relationship (Type, Print): Gregory R. Van de Visser/Grandson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6355 Ganeys Wharf Road, Preston, Maryland 21655

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Nama of cematary, crematory or other place): Chesapeake Cremation Center/May

Date: 12, 1998

20c. Location - City or Town, State: Stevensville, MD

21. Signature of Funeral Service Licansee: Maurice F. Newman Jr.

22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 200 S. Harrison Street, Easton, Maryland 21601

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Sepsis	6 wks
Due to (or es e consequence of): b.	Vancomycin Resistant Enterococcus	6 wks.
Sequentially list conditions, if any, leading to immadiate causa. Entar Underlying Cause (Disease or Injury that Initiated events rasulting in death) Last — Due to (or as a consequence of): c.	Urinary Tract Infection	
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hip fracture 2/98

wound infection

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Phyaician**: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner**: On the basis of exemination and/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Karen Moffett

29c. License number: D51639

29d. Data signed (Month, Day, Year): MAY 11, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): KAREN MOFFETT, M.D. P.O. BOX 660 DENTON, MD 21629

State Registrar

31. Date filed (Month, Day, Year): MAY 13 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rav 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requiras that the death certificata be axecuted within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16349

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Kathryn Elaine Leshev

2. Dete of Deeth: Month 05 Dey 12 Yeer 1998

3. Time of Death: 4:25 pm

4e. Facility Nema (If not institution, give street end number): Chestertown Nursing & Rehabilatiation Center

4b. City, Town, or Location of Deeth: Chestertown

4c. County of Deeth: Kent

Funeral Director

5. Social Security Number: 723-18-9474

6. Sex: 1☐ M 2☒F

7. Age (In yrs. last birthdey): 58 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): August 13, 1939

9. Birthplece (Stete or Foreign Country): Lebadon, PA

Usuel Residenca of Decedent

10e. State: Maryland

10b. County: Kent

10c. City, Town or Location: Chestertown

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street end Number: 101 Morgnec Road 301D

10f. Zip Code: 21620

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Stetus: 1☒Never Married 2☐ Married 3☐ Widowed 4☐ Divorcad

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12 | Collage (1-4or 5+): 4

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Nurse Adminstrator

16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): Edward Clarence Lesher, Sr

18. Mother's Name (First, Middle, Meiden Surname): Margaret Linkswiler

19e. Informent's Name/Relationship (Typa, Print): Stanley Savitz/Friend

19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 12522 Valley Pines Drive, Reisterstown, MD 21136

20e. Method of Disposition: 1☒Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Othar (Specify)

20b. Plece of Dispositon (Name of cemetery, cremetory or other piece): Eibeneizer Cemetery

Dete:

20c. Location - City or Town, Stete: Lebadon, PA

21. Signeture of Funeral Service Licensee: [signature] M-00937

22. Nema end Address of Feciity: Fellows, Helfenbein, & Newnam Funeral Home, PA 130 Speer Road, Chestertown, MD 21620

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each lina.

Approximete Interval Between Onset end Death

Immediete Causa (Final diseese or condition resulting in death)

a. Respiratory Arrest — 6 hrs

Dua to (or as e consequence of):

b. Motastatic Breast Cancer

Sequantially list conditions, if eny, leeding to immadiate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Lest

Due to (or es e consaquence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.: HTN, DM Type II

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined

28e. Deta of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Spacify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of examinetion end/or investigation, in my opinion, daeth occurred et tha time, deta end piece, and dua to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: [signature]

29c. License number: D50996

29d. Date signed (Month, Dey, Yeer): 5/12/98

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Neil Stoddard 100 Brown Street, Chestertown, MD 21620

State Registrar

31. Data filed (Month, Day, Year): MAY 15 '98

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16350

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Avaleen W. Lane
2. Date of Death (Month, Day, Year): May 9, 1998
3. Time of Death: 1:20 AM
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 229-03-5945
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9/24/18
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Olney
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 17108 Fitzroy Way
10f. Zip Code: 20832
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Academic Affairs

17. Father's Name (First, Middle, Last): Edward Whitlock
18. Mother's Name (First, Middle, Maiden Surname): Alma Talley

19a. Informant's Name/Relationship (Type, Print): Donna L. Edmunds / daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17108 Fitzroy Way Olney Maryland 20832

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): Alrington National Cem.
Date: 5/19/98
20c. Location - City or Town, State: Arlington Virginia

21. Signature of Funeral Service Licensee: ▶ Tony Blackburn
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Spring MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Severe Cardio Myopathy	Five years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hypotension	Four days
	Due to (or as a consequence of):	
	c. Congestive Heart Failure	Four days
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28c. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier: ▶ Bennett Morrison MD
29c. License number: D 47682
29d. Date signed (Month, Day, Year): May 9, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bennett Morrison 2901 Olney-Sandy Spring Road, Olney, Maryland, 20832

State Registrar

31. Date filed (Month, Day, Year): MAY 14 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

JW

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16351

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNE M. LEVENTHAL
2. Date of Death (Month, Day, Year): MAY 7, 1998
3. Time of Death: 3:35PM
4a. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579-07-8443
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 22, 1914
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: CHEVY CHASE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8100 CONNECTICUT AVE. #621
10f. Zip Code: 20815
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SELF-EMPLOYED
16b. Kind of Business/Industry: RETAIL FURNITURE

17. Father's Name (First, Middle, Last): HARRY MINOVITZ
18. Mother's Name (First, Middle, Meiden Surname): TANYA DOZOR

19a. Informant's Name/Relationship (Type, Print): HELENE WILDER-DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6508 LANDON LANE-BETHESDA, MARYLAND 20817

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CEMETERY OF ADAS ISRAEL
Date: 5-11-98
20c. Location - City or Town, State: WASHINGTON, DC

21. Signature of Funeral Service Licensee: Robert Zummer
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	RESPRIATORY FAILURE	5 MINUTES
Due to (or as a consequence of):	LUNG CANCER	1 YEAR
Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Othar significsnt conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco usa contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Catherine F. McCoy
29c. License number: D35293
29d. Date signed (Month, Day, Year): May 7, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CATHERINE F. MCCOY-MD-SUBURBAN HOSPITAL-OLD GEORGETOWN RD. BETHESDA, MARYLAND

State Registrar

31. Date filed (Month, Day, Year): MAY 11 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

BMW

Anne Leventhal 335 P 5-7-98

20

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16352

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Chuan-Min Li

2. Date of Death: Month May, Day 9, Year 1998

3. Time of Death: 1:25 PM

4a. Facility Name (If not institution, give street and number): 12012 Ashley Drive

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 146-56-5816

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 8, 1929

9. Birthplace (State or Foreign Country): China

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 12012 Ashley Drive

10f. Zip Code: 20852

10g. Citizen of What Country? Republic of China

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Kitchen Assistant

16b. Kind of Business/Industry: Marriott Corporation

17. Father's Name (First, Middle, Last): Li Bor Zang

18. Mother's Name (First, Middle, Maiden Surname): Chang Su Chuan

19a. Informant's Name/Relationship (Type, Print): George Li/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12012 Ashley Drive, Rockville, Maryland 20852

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery

Date: May 13, 1998

20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: Ray Faul

M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Metastatic Esophageal Cancer

Due to (or as a consequence of):

Colon Cancer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John L. Marshall

29c. License number: DC 19655

29d. Date signed (Month, Day, Year): May 11, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John L. Marshall, M.D. 3800 Reservoir Road, N.W., Washington, D.C. 20007

State Registrar

31. Date filed (Month, Day, Year): MAY 14 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

JW

4

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16353

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lillian Small Lichtenberg

2. Data of Death — Month: May; Day: 11; Year: 1998

3. Time of Death: 11:30am

4a. Facility Name *(If not institution, give street and number)*: Hebrew Home

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-09-2699

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 92 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: Sept.19,1905

9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6121 Montrose Rd.

10f. Zip Code: 20852

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: XX

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales

16b. Kind of Business/Industry: Department Store

17. Father's Name *(First, Middle, Last)*: Isadore Small

18. Mother's Name *(First, Middle, Maiden Surname)*: Sarah Rappaport

19a. Informant's Name/Relationship *(Type, Print)*: Warren Lichtenberg/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10300 West Lake Dr. Bethesda, MD 20817

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Judean Mem. Gdns.

Date: 5/13/98

20c. Location - City or Town, State: Olney, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Ives-Pearson Funeral Home 2847 Wilson Blvd. Arlington, VA 22201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE — MONTHS

Due to (or as a consequence of):

b. COPD — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequance of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA, HYPERTENSION

CARCINOMA OF BREAST

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D 05885

29d. Date signed *(Month, Day, Year)*: 5/11/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): STEVEN LIPSON 6121 MONTROSE RD, ROCKVILLE

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 15 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16354

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT LIMON
2. Date of Death (Month, Day, Year): May 12, 1998
3. Time of Death: 6:30P.
4a. Facility Name (If not institution, give street and number): 4423 Romlon Street, #2
4b. City, Town, or Location of Death: BELTSVILLE
4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 577-09-5165
6. Sex: XX M 2☐ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 13,1914
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Beltsville
10d. Inside City Limits: 1☐ Yes 2 XX No
10e. Street and Number: 4423 Romlon Street, #2
10f. Zip Code: 20705
10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3 XX Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 XX Yes 2☐ No — If Yes, Give Yaar or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.): 1☐ Yes XX No Specify:
14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+): 2½
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Jeweler
16b. Kind of Business/Industry: Self Employed

17. Father's Nama (First, Middle, Last): Jacob Limon
18. Mother's Name (First, Middle, Maiden Surneme): unknown

19a. Informant's Name/Relationship (Type, Print): Clifford F. Limon, Jr. (grandson)
19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 11091 Scotts Landing Rd. Laurel, Maryland 20723

20a. Method of Disposition: 1 XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Md. Veterans Cemetery
Date: 5/15/1998
20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: Donald V. Borgwardt.
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediete Ceuse (Final diseese or condition resulting in deeth)
e. End stage Ischemic Cardiomyopathy
Due to (or as a consequence of):
b. Congestive heart failure.
Due to (or as a consequence of):
c. Chronic Renal Failure
Due to (or as a consequence of):
d. Chronic obstructive lung Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet Initieted events resulting in deeth) Last

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1☐ Yes 2 XX No
24b. Were autopsy findings avelleble prior to completion of causa of death? 1☐ Yes XX No

25. Was case referred to medical examiner? 1☐ Yes 2 X No
26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5 XX Residenca 8☐ Other (Specify)

27. Manner of Death: 1 XX Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 XX **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Ashwani Kumar Bassi MD
29c. Licansa number: D 37250
29d. Data signed (Month, Day, Year): May 13, 1998
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Ashwani K. Bassi, M.D. 325 Hospital Drive, Suite 108 Glen Burnie, Maryland 21061

State Registrar

31. Date filed (Month, Dey, Year): MAY 15 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 98 16355

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Minnie B. Lovett
2. Date of Death Month / Day / Year: May 12, 1998
3. Time of Death: 3:45 PM
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 200-52-0516
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 8, 1911
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9109 Sudbury Road
10f. Zip Code: 20901
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name *(First, Middle, Last)*: Abraham Lawitt
18. Mother's Name *(First, Middle, Maiden Surname)*: Helen (Unavailable)
19a. Informant's Name/Relationship *(Type, Print)*: Helaine Michaels-Klein (daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Same as 10
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory
Date: 5-14-98
20c. Location - City or Town, State: Beltsville, Maryland
21. Signature of Funeral Service Licensee: Ellen H. Rapp
22. Name and Address of Facility: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory failure — 1 day
Due to (or as a consequence of):
b. Aspiration Pneumonia — 1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Amendhirallo
29c. License number: D38262
29d. Date signed *(Month, Day, Year)*: 5/13/98
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Mendhiratta, 18111 Prince Philip Drive Olney MD 20832

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 15 1998
32. Registrar's Signature: Jutta Davidson-Randell

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Brew

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16356

Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Logan, William

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name *(First, Middle, Last)*: William Nigh LOGAN

2. Date of Death Month: May Day: 7 Year: 1998

3. Time of Death: 0210

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

5. Social Security Number: 219-05-2086

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 9 1916

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1124 Cottage Court

10f. Zip Code: 21740

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk

16b. Kind of Business/Industry: Hardware

17. Father's Name *(First, Middle, Last)*: Fraener Logan

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Nigh

19a. Informant's Name/Relationship *(Type, Print)*: Helen A. Logan - Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1124 Cottage Court Hagerstown, Maryland 21740

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rest Haven Cemetery

Date: 5/9/98

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott M Minnich

22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Massive Intestine Infarction — 24 hrs

Due to (or as a consequence of):

b. Mesenteric artery occlusion — 24 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. arterio sclerotic Cardiovascular Disease — years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D 18127

29d. Date signed *(Month, Day, Year)*: 5/7/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): C.C.Su. M.D. 370 Mill St. Hagerstown Md 21740

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 08 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16357

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VIOLA MAY LIDA

2. Date of Death Month: MAY Day: 9, Year: 1998

3. Time of Death: 6:00 pm

4a. Facility Name (If not institution, give street and number): WASHINGTON CO. HOSPITAL

4b. City, Town, or Location of Death: HAGERSTOWN

4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 229-30-8018

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 20, 1930

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 161 Summit Avenue

10f. Zip Code: 21740

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6

College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own home

17. Father's Name (First, Middle, Last): William Henry Courtney

18. Mother's Name (First, Middle, Maiden Surname): Marie Swortzel

19a. Informant's Name/Reletionship (Type, Print): Michael W. Lida

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11106 Lakeview Drive, Hagerstown, Maryland 21740

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Cedar Lawn Memorial Park

Date: 05-12-98

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: R. Neal Brady

22. Name and Address of Facility: Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediete Cause (Final disease or condition resulting in death)

a. Respiratory failure

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. congestive Heart Failure

Dua to (or as a consequence of):

c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequance of):

d. ASP. PNEUMONIA

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Lung Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D 50882

29d. Data signed (Month, Day, Year): 5/7/98

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): NEAL PATALINGHUG, M.D. 11110 MEDICAL CAMPUS DRIVE SUITE 107 HAGERSTOWN MD 21740

State Registrar

31. Date filed (Month, Day, Year): MAY 12 1998

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Viola Lida

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16358

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DOROTHY SULLIVAN LYONS
2. Date of Death — Month: May; Day: 12; Year: 1998
3. Time of Death: 5:3[illegible] a.m.
4a. Facility Name *(If not institution, give street and number)*: 29646 Dutchmans Lane
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 217-30-7648
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 66 Yrs.
If Under 1 Year — Months: ; Days:
If Under 24 Hrs. — Hours: ; Min.:
8. Date of Birth *(Month, Day, Year)*: Jan. 31, 1932
9. Birthplace *(State or Foreign Country)*: Easton, MD

Usual Residence of Decedent

10a. State: Maryland
10b. County: Talbot
10c. City, Town or Location: Easton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 29646 Dutchmans Lane
10f. Zip Code: 21601
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: Domestic/Own Home

17. Father's Name *(First, Middle, Last)*: Douglas M. Sullivan
18. Mother's Name *(First, Middle, Maiden Surname)*: Ellen Corkran

19a. Informant's Name/Relationship *(Type, Print)*: Charles R. Lyons, Jr./Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 29646 Dutchmans Lane, Easton, Maryland 21601

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Spring Hill Cemetery/May 15, 1998
20c. Location - City or Town, State: Easton, Maryland

21. Signature of Funeral Service Licensee: ▶ M. Ed Dee[illegible] III C.F.S.P.
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 200 S. Harrison Street, Easton, Maryland 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — 6 mos
Due to (or as a consequence of):
b. ASHD with Congestive Cardiomyopathy — Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus with Peripheral Neuropathy
Peripheral Vascular Disease with Bilateral BKA Amputation
End Stage Renal Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ William Harwood Jr
29c. License number: D08715
29d. Date signed *(Month, Day, Year)*: 5/13/98
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William H. Wood EASTON, MD 21601

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 15 1998
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16359

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BERNARD ANGELO MESSINA, JR.

2. Date of Death Month Day Year: MAY 12, 1998

3. Time of Death: 8:07 AM.

4a. Facility Name *(If not Institution, give street and number)*: CARROLL COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death: WESTMINSTER

4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 184-34-9931

6. Sex: [X] 1 M [ ] 2 F

7. Age *(In yrs. last birthday)*: 54 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 7/21/1943

9. Birthplace *(State or Foreign Country)*: PENNSYLVANIA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD.

10b. County: CARROLL

10c. City, Town or Location: WESTMINSTER

10d. Inside City Limits: [ ] 1 Yes [X] 2 No

10e. Street and Number: 3359 LITTLESTOWN PIKE

10f. Zip Code: 21158

10g. Citizen of What Country?: USA.

11. Marital Status: [ ] 1 Never Married [ ] 2 Married [ ] 3 Widowed [X] 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? [X] 1 Yes [ ] 2 No If Yes, Give Year or Dates: VIETNAM

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) [ ] 1 Yes [X] 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 9 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MACHINE OPERATOR

16b. Kind of Business/Industry: OIL FIELDS

17. Father's Name *(First, Middle, Last)*: BERNARD ANGELO MESSINA, SR.

18. Mother's Name *(First, Middle, Meiden Surneme)*: FRANCES LEONA GINNERY

19a. Informant's Name/Relationship *(Type, Print)*: FRANK A. MESSINA -BROTHER

19b. Malling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 3359 LITTLESTOWN PIKE, WESTMINSTER, MD.21158

20e. Method of Disposition: [X] 1 Burial [ ] 2 Cremation [ ] 3 Removal from State [ ] 4 Donation [ ] 5 Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: CALVARY CEMETERY

Dete: 5/16/98

20c. Location - City or Town, State: OIL CITY, PA.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer — 1year

Due to (or as a consequence of):

Sequantially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Disease or Injury that Initieted events resulting in deeth) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequenca of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the causa of death? [X] 1 Yes [ ] 2 No [ ] 3 Probably [ ] 4 Unknown

24a. Wes en eutopsy performed? [ ] 1 Yes [X] 2 No

24b. Were eutopsy findings available prior to completion of cause of deeth? [ ] 1 Yes [ ] 2 No

25. Was cese referred to medicel examiner? [ ] 1 Yes [X] 2 No

26. Place of Death *(Check only one)*: Hospital: [X] 1 Inpatient [ ] 2 ER/Outpatient [ ] 3 DOA Other: [ ] 4 Nursing Home [ ] 5 Residence [ ] 8 Other *(Specify)*

27. Manner of Death: [ ] 1 Natural [X] 2 Accident [ ] 3 Suicide [ ] 4 Homicide [ ] 5 Panding investigation [ ] 6 Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? [ ] 1 Yes [ ] 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: [X] 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. [ ] 2 **Medical Examiner**: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to tha cause(s) end manner stated.

29b. Signature and title of certifier: [signature] Philip Knotts

29c. License number: D24321

29d. Date signed *(Month, Dey, Year)*: 5/12/98

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): Philip H. Knotts 2059 Baltimore Blvd Finksburg, Md 21048

State Registrar

31. Date filed *(Month, Dey, Year)*: MAY 13 1998

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Manuel Marquez
2. Date of Death Month / Dey / Yeer: May 6, 1998
3. Time of Death: 09:50pm
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-54-0575
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Yeer)*: Dec. 26, 1920
9. Birthplace *(State or Foreign Country)*: Bolivia

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street end Number: 4001 Ferrara Avenue
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Merried 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☒ Yes 2 ☐ No *Specify:* Bolivian
14. Race - American Indian, Bleck, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cartographer
16b. Kind of Business/Industry: Automotive Travel
17. Fether's Name *(First, Middle, Last)*: Juvenal Reyes
18. Mother's Name *(First, Middle, Maiden Surneme)*: Filomena Marquez
19a. Informent's Neme/Reletionship *(Type, Print)*: Esperanza Marquez (wife)
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 4001 Ferrara Avenue, Silver Spring, MD 20906
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Parklawn Memorial Park — Dete: 5/11/98
20c. Location - City or Town, State: Rockville, MD
21. Signature of Funerel Service Licensee: James H Steinj
22. Neme end Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Bond $

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Cause (Final disease or condition resulting in deeth)
- a. aspiration pneumonia — one week
- Due to (or es a consequence of):
- b. chronic dementia — two years

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest
- Due to (or es e consequence of):
- c.
- Due to (or es a consequenca of):
- d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: chronic renal failure; intermittent vein stricture

23b. Did tobacco use contribute to the ceuse of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings aveileble prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☐ No

26. Place of Deeth *(Check only one)*: Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Menner of Deeth: 1 ☐ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigetion 6 ☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how Injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) end menner es steted. 2 ☐ **Medicel Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and piece, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: Mark S Rosen
29c. License number: D 20400
29d. Date signed *(Month, Dey, Yeer)*: May 7, 1998

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Mark S. Rosen MD 3941 Ferrera Drive Silver Spring Md 20906

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: MAY 11 1998
32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16361

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Francis McKeever

2. Date of Death — Month: May; Day: 9; Year: 1998

3. Time of Death: 7 PM

4a. Facility Name *(If not institution, give street and number)*: 17501 Old Baltimore Road

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-20-6639

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan 27, 1922

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Olney

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 17501 Old Baltimore Road

10f. Zip Code: 20832

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: 1943-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Foreman

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Robert L. McKeever

18. Mother's Name *(First, Middle, Maiden Surname)*: Regina K. Kellerman

19a. Informant's Name/Relationship *(Type, Print)*: Hope McKeever (wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 17501 Old Baltimore Road, Olney, MD 20832

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: 5/14/98

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Steven J Stemel

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Blue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer — Due to (or as a consequence of): — 5+ Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D33685

29d. Date signed *(Month, Day, Year)*: May 11, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kenneth D. Miller, M.D. 18111 Prince Philip Dr., Olney, MD 20832

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 12 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5 + 1

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16362

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anthony Joseph McMahon

2. Date of Death: Month: May Day: 5 Year: 1998

3. Time of Death: 3:50 PM

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 493-20-6349

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 2, 1911

9. Birthplace (State or Foreign Country): Missouri

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2201 Colston Drive, Apt. 610

10f. Zip Code: 20910

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: 1943-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): | College (1-4or 5+): 5+

18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrator

16b. Kind of Business/Industry: Federal Government

17. Father's Neme (First, Middle, Last): Thomas Andrew McMahon

18. Mother's Name (First, Middle, Maiden Surname): Marie Hedderman

19a. Intormant's Name/Relationship (Type, Print): Mary Margaret McMahon (wife)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 2201 Colston Drive, Apt. 610, Silver Spring, MD 20910

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other place): Gate of Heaven Cemetery

Date: 5/9/98

20c. Location - City or Town, State: Silver Spring, MD

21. Signeture of Funerel Service Licensee: ▶ Steven J Strong

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert teilure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in death): a. Respiratory failure

Due to (or as a consequence of): b. Aspiration Pneumonia

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or es a consequenca of): c.

Due to (or as a consequenca of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Acute Myocardial Infarction

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☒ inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 8☐ Other (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, tectory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, and due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: ▶ Rajindra K. Saini

29c. License number: D13548

29d. Date signed (Month, Day, Year): 5.6.98

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): RAJINDRA K. SAINI 10801 Lockwood Drive Silver Spring MD 20901

State Registrar

31. Date filed (Month, Day, Yeer): MAY 11 1998

32. Registrer's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16363

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Walter Sparks Measday III

2. Date of Death Month Day Year: May 8, 1998

3. Time of Death: 1:55 AM

4a. Facility Name *(If not institution, give street and number)*: 6902 Dartmouth Avenue

4b. City, Town, or Location of Death: College Park

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 231-12-5253

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 18, 1920

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: College Park

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 6902 Dartmouth Avenue

10f. Zip Code: 20740

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: WW II

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Economist

16b. Kind of Business/Industry: Government

17. Fether's Neme *(First, Middle, Last)*: Walter Measday

18. Mother's Name *(First, Middle, Maiden Surname)*: Virginia Sparks

19a. Informent's Name/Reletionship *(Type, Print)*: Alex Measday (son)

19b. Malling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4357 Leatherwood Terrace Burtonsville, Maryland 20866

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: 5/13/98

20c. Location - City or Town, State: Silver Spring,Maryland

21. Signature of Funeral Service Licensee: Steven D Stroud

22. Name end Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in death) e. Ischemic Cardiomyopathy — 2 Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Lest

b. Atherosclerotic Coronary Artery Disease — 20 Years

Due to (or as a consequence of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the causes of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was en eutopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

26. Piece of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date end piece, end due to the cause(s) and manner steted.

29b. Signeture and [illegible]

29c. License number: D 37975

29d. Date signed *(Month, Dey, Year)*: May 8, 1998

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): Jeffrey P. Indrisano, M.D. 10801 Lockwood Drive Silver Spring,Maryland 20901

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 12 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16364

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stanley Gronau Mouser
2. Date of Death (Month, Day, Year): May 12, 1998
3. Time of Death: 1:10 p.m.

4a. Facility Name (If not institution, give street and number): 6212 Poindexter Lane
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-32-6866
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 16,1930
9. Birthplace (State or Foreign Country): Hagerstown, MD

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6212 Poindexter Lane
10f. Zip Code: 20852
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Korean
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): +1 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Proprietor
16b. Kind of Business/Industry: George W. Allen Office Supply Company

17. Father's Name (First, Middle, Last): Loris Nace Mouser
18. Mother's Name (First, Middle, Melden Surname): Margaret Benner

19a. Informant's Name/Relationship (Type, Print): Barbara Allen Mouser
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6212 Poindexter Lane, Rockville, MD 20852

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate Of Heaven Cemetery
Date: 5/15/98
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Joseph Gawler's Sons
22. Name and Address of Facility: Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue N.W., Washington, D.C. 20016

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Malestatic adeno carcinoma of brain — 9 mo
Due to (or es e consequence of):
b. primary unknown
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part fl. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Sulcide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: Jeremy V. Cooke MD
29c. License number: D04602
29d. Date signed (Month, Day, Year): 5/13/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeremy V. Cooke MD 10400 Conn Ave, Kensington Md 20895

State Registrar

31. Date filed (Month, Day, Year): MAY 14 1998
32. Registrar's Signature: Julia Davidson-Randell

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

JW

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16365

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Mary Duckery Nickerson

2. Dete of Deeth Month / Day / Yeer: May 8th, 1998

3. Time of Death: 3:45 pm

4e. Facility Neme *(If not institution, give street end number)*: Magnolia Hall Nursing Home

4b. City, Town, or Location of Deeth: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 213-18-4987

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Dec. 04-1914

9. Birthplace *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: Md.

10b. County: Kent

10c. City, Town or Location: Worton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 25854 E. Hill Rd.

10f. Zip Code: 21678

10g. Citizen of Whet Country?: USA

11. Marital Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexlcan, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 7th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Domestic

16b. Kind of Business/Industry: Housework

17. Father's Neme *(First, Middle, Last)*: Raymond Duckery

18. Mother's Name *(First, Middle, Meiden Surneme)*: Areba Ray Hackett

19e. Informent's Name/Reiationship *(Type, Print)*: Mrs. Mary F. Wilson (Daughter

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: P.O. Box 118 Still Pond, Maryland 21667

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: NCCOL Cemetery

Dete: 4-16-98

20c. Location - City or Town, Stete: Still Pond, Maryland

21. Signeture of Funeral Service Licensee: ▶ Joyce E. Walley

22. Neme end Address of Facility: WALLEY FUNERAL HOME 207 Calvert St. Chestertown, Md. 21620

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part I. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel diseese or condition resulting in deeth)

a. Pulmonary Embolism — Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Cause (Disease or injury thet Initiated events resulting in deeth) Lest

b. — Due to (or as e consequence of):

c. — Due to (or es e consequence of):

d.

Minutes

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Pert I.

① Atherosclerotic Heart Disease ② Insulin Dependant D.M. ③ CHF ④ Old CVA ⑤ Large bed sore ⑥ Senility

23b. **Did tobacco use contribute to the cause of deeth?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese reterred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: ▶ K.K. Wun, MD.

29c. License number: D21313

29d. Date signed *(Month, Dey, Yeer)*: 5/15/98

30. Neme end address of person who completed ceuse of death (Item 23a) (Type, Print): Kin Kue Wun 223 High St. Chestertown, Maryland 21620

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: MAY 15 '98

32. Registrer's Signeture: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16366

Amend: #1 Per MD Film G760 6-12-98RC

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frances Elizabeth NICOLS ~~Nichols~~

2. Date of Death (Month, Day, Year): May 1, 1998

3. Time of Death: 1:00A.

4a. Facility Name *(If not institution, give street and number)*: Friends House Nursing Home

4b. City, Town, or Location of Death: Sandy Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 216-03-8072

8. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 99 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: January 2, 1899

9. Birthplace *(State or Foreign Country)*: Columbus, Ohio

Usual Residence of Decedant

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Sandy Springs

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 17340 Quaker Lane

10f. Zip Code: 20860

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Banking Adminstrative Assistant

16b. Kind of Business/Industry: Banking

17. Father's Name *(First, Middle, Last)*: Irvin Nichols

18. Mother's Name *(First, Middle, Malden Surname)*: Emily Ringgold

19a. Informant's Name/Relationship *(Type, Print)*: Deborah Hanraham/Niece

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 1505 Q St, NW Washington, DC 20009

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cemetery, crematory or other piece)*: St. Pauls Cemetery

Date: May 6, 1998

20c. Location - City or Town, State: Chestertown, MD

21. Signature of Funeral Service Licensee: Kirk A. Helfenbein

22. Nama and Address of Facility: Fellows, Helfenbein, & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in daath)

a. HYPOSTATIC BRONCHOPHEUMONIA TERM.

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Entar Underlying Causa (Disaase or injury that initiated avants resulting in daath) Last

b.

Due to (or as a consequance of):

c.

Due to (or as a consequence of):

d. DEMENTIA, ALZHEIMERS YEARS

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case raferred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Chack only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Spacify)*

28f. Location *(Streat and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha bast of my knowledga, daath occurred at the tima, data and placa, and due to the causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, daath occurred at the time, date and placa, and dua to tha cause(s) and manner statad.

29b. Signature and title of certifier: Donald R Lewis MD

29c. License number: D06406

29d. Date signed *(Month, Day, Year)*: May 1, 1998

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Donald R. Lewis, M.D. 4000 Olney-Laytonsville Rd. Olney, M.D. 20832

State Registrar

31. Date filed (Month, Day, Year): MAY 05 98

32. Registrar's Signature: Gina Davidson-Randall

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16367

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: IVA CAROLYN PIETROWSKI
2. Date of Death: Month APRIL Day 21 Year 1998
3. Time of Death: 2145
4a. Facility Name *(If not Institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 218-20-5967
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: OCT. 29, 1926
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: DORCHESTER
10c. City, Town or Location: EAST NEW MARKET
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6311 SNUG HARBOR ROAD
10f. Zip Code: 21631
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ASSEMBLY LINE WORKER
16b. Kind of Business/Industry: MANUFACTURING

17. Father's Name *(First, Middle, Last)*: IRVING P. BOUNDS
18. Mother's Name *(First, Middle, Maiden Surname)*: CARRIE FEARSON

19a. Informant's Name/Relationship *(Type, Print)*: LINDA COVIELLO
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3647KC, LINKWOOD, MARYLAND 21835

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: OUR LADY OF GOOD COUNSEL
Date: 4/24
20c. Location - City or Town, State: SECRETARY, MARYLAND

21. Signature of Funeral Service Licensee: Leonard Zeller
22. Name and Address of Facility: ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD 21631

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ruptured thoracic aortic aneurysm — 4/29/98

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

acute pneumococcal sepsis
old cerebrovascular accident
chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rodney C Wenrick MD
29c. License number: D15384
29d. Date signed *(Month, Day, Year)*: MAY 13, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rodney C. Wenrick M.D. 100 Power Street, Salisbury md 21804

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 15 1998
32. Registrar's Signature: Jubi Mudson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16368

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Rita Pauline Peterson

2. Dete of Deeth Month / Dey / Yeer: May 11, 1998

3. Time of Death: 6:18 p.m.

4e. Facility Neme *(If not institution, give street end number)*: 2909 Millington Road

4b. City, Town, or Location of Death: Millington

4c. County of Deeth: Queen Anne's

Funeral Director

5. Social Security Number: 235-80-2208

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthdey)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: October 12, 1917

9. Birthplece *(Stete or Foreign Country)*: Ireland, W. VA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Queen Anne's

10c. City, Town or Location: Millington

10d. Inside City Limits: 1☐ Yes 2☐ No

10e. Street end Number: 2909 Millington Road

10f. Zip Code: 21651

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- if Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondery (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Neme *(First, Middle, Last)*: Clodian Chipps

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Mary Letoa McClain

19e. Informent's Neme/Relationship *(Type, Print)*: Eric L. Peterson/Son

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 620 Baxter Rd, Sudlersville, MD 21668

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Crumpton Cemetery

Dete: May 15, 1998/ Crumpton, MD

20c. Location - City or Town, State

21. Signeture of Funerel Service Licensee: [signature]

22. Neme end Address of Feciility: Fellows, Helfenbein, & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one cause on each line.

Approximete Interval Between Onset and Deeth

Immediete Cause (Final diseese or condition resulting in deeth) e. Cardio Respiratory Arrest — 8 hrs.

Due to (or es e consequence of): ASCVD / CAD

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es a consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

S/P CABG / S/P PTCA / DM / HTN / HChol. / Osteoporosis / Depression / CHF / Peripheral Vasc Dz / Valvular Dz Mitral & Aortic Regurg. Tricuspid Regurg.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es stated. 2☐ **Medicel Exeminer:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) and menner stated.

29b. Signeture end title of certifier: [signature]

29c. License number: D 50996

29d. Dete signed *(Month, Dey, Yeer)*: 5/14/98

30. Neme end eddress of person who completed cause of deeth (item 23e) (Type, Print)

State Registrar

31. Dete filed *(Month, Day, Yeer)*: MAY 15 '98

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16369

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LAWRENCE J. PIERCE
2. Date of Death (Month, Day, Year): MAY 8 1998
3. Time of Death: 0617 AM
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 186-24-0539
6. Sex: 1 X M 2 F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 1, 1931
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residance of Decadant

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Derwood
10d. Inside City Limits: 1 Yes 2 X No
10e. Street and Number: 7241 Mill Run Drive
10f. Zip Code: 20855
10g. Citizen of What Country?: United States

11. Marital Status: 1 Never Married 2 X Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 1954-1956
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Procurement Director
16b. Kind of Business/Industry: Government Contracts

17. Father's Name (First, Middle, Last): Howard C. Pierce
18. Mother's Name (First, Middle, Maiden Surname): Margaret McCarthy

19a. Informant's Name/Relationship (Type, Print): Annie F. Pierce, Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7241 Mill Run Drive, Derwood, MD 20855

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: May 11, 1998
20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. PNEUMONIA — TWO WEEKS

Due to (or as a consequence of):
b. CHRONIC RENAL FAILURE — SEVERAL YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Philip Jay Lawlor MD
29c. License number: D24398
29d. Date signed (Month, Day, Year): MAY 8, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PHILIP JAY LAWLOR MD 15224 SHADY GROVE RD SUITE 302 ROCKVILLE MD 20850

State Registrar

31. Date filed (Month, Day, Year): MAY 11 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16370

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Janice M. Page
2. Dete of Deeth Month May Dey 5, Yeer 1998
3. Time of Death: 11:20 AM
4e. Facility Neme (If not institution, give street end number): Holy Cross Hospital
4b. City, Town, or Location of Deeth: Silver Spring
4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 528-20-0296
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthday): 74 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): Sept. 24, 1923
9. Birthplace (State or Foreign Country): Utah

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 8601 Manchester Drive #506
10f. Zip Code: 20901
10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12); College (1-4or 5+): 5+
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Professor
16b. Kind of Business/Industry: Montgomery County College

17. Fether's Neme (First, Middle, Last): George W. Page
18. Mother's Neme (First, Middle, Meiden Surneme): Irene Wrathall

19a. Informent's Neme/Reletionship (Type, Print): William J. Scott/Attorney
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 25 West Middle Lane, Rockville, Maryland 20850

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Montgomery Crematorium, Inc. Date: May 10, 1998
20c. Location - City or Town, Stete: Bethesda, Maryland

21. Signeture of Funeral Service Licensee: Ronald Faust M00198
22. Neme end Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

		Approximete Intervel Between Onset end Death
Immediate Ceuse (Finel diseese or condition resulting in deeth) e.	RESPIRATORY FAILURE	1 WEEK
Due to (or es e consequence of):		
Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest b.	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	4 YRS
Due to (or es e consequence of):		
c.	SMOKING	
Due to (or as e consequence of):		
d.		

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: COR PULMONALE; HYPOTHYROIDISM

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

28. Piece of Deeth (Check only one): Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner es steted. 2☐ **Medical Examiner:** On the besis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner stated.

29b. Signeture end titie of certifier: Steven Tikaria
29c. License number: D36252
29d. Dete signed (Month, Day, Year): MAY 05, 1998

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): STEVEN T. KARIYA, MD, 11501 GEORGIA AVE STE 515, WHEATON MD 20902

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 11 1998
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, pege 2 should be detached for use es the burial-transit permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If Item 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16371

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Se-gun Park	May 13, 1998	6:19 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Prince Georges Hospital	Cheverly	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
392-42-1444	1☒ M 2☐ F	61 Yrs.			Jan. 6, 1937	Korea

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Hyattsville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7004 Lovell Drive	20782	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Asian

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Electronics Engineer	Federal Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Unknown Park	Young Sook Ko

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Byung Soon Park (wife)	7004 Lovell Drive, Hyattsville, MD 20782

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	National Memorial Park	5/16/98	FallsChurch, Virginia

21. Signature of Funeral Service Licensee ▶ Steven D Strand

22. Name and Address of Facility Francis J. Collins Funeral Home, Inc, 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
tmmediate Causa (Final disaase or condition resulting in death)	a. HEPATOCELLULAR CARCINOMA	Month
	Due to (or as a consequence of): HEPATIC ENCEPHALOPATHY	4 days
Sequentially tist conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet tnitieted events resulting tn death) Last	b. Due to (or as e consequence of): HEPATIC FAILURE	4days
	c. Due to (or as a consequence of):	
	d.	

Part tt. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death	28a. Date of tnjury (Month, Day Year)	28b. Time of tnjury	28c. tnjury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of tnjury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one) 1☒ **Certifying Phyalcian:** To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) end menner as stated. 2☐ **Medtcat Examiner:** On the basis of examination and/or investigation, tn my opinion, death occurred at the time, date and placa, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D50686	MAY 14, 1998

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) G.S. CHHABRA 8215 WISCONSIN AVENUE BETHESDA MD 20814

State Registrar

31. Dete fited (Month, Day, Year)	32. Registrar's Signature
MAY 15 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

Medical Certification: To Be Completed by Physician/Medical Examiner

BMD

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16372

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret Luciele POTTS
2. Date of Death Month Day Year: May 8, 1998
3. Time of Death: 9:30 p.m.
4a. Facility Name *(If not institution, give street and number)*: Clearview Nursing Home
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 220-09-4107
8. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept.12,1919
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1749 Edgewood Hill Circle
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: telephone receptionist
16b. Kind of Business/Industry: electric

17. Father's Name *(First, Middle, Last)*: Harry Potts
18. Mother's Name *(First, Middle, Maiden Surname)*: Lela Grace Summers

19a. Informant's Name/Relationship *(Type, Print)*: John R. Potts, nephew
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1749 Edgewood Hill Circle, Hagerstown, Md. 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rose Hill Cemetery
Date: 5-11-98
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott Minnich
22. Name and Address of Facility: MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Urosepsis — 7 days

Due to (or as a consequence of):
b. Urinary Tract Infection, chronic intermittent — many yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Neurogenic bladder — many yrs

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alzheimers Disease

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Edward Moody MD
29c. License number: 007857
29d. Date signed *(Month, Day, Year)*: 5/9/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. E. B. Moody, 1190 Mt. Aetna Road, Hagerstown, Md. 21740

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 11 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16373

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Matilde Rodriguez
2. Date of Death Month: Apr Day: 26 Year: 1998
3. Time of Death: 3:10 PM
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Mont.

Funeral Director

5. Social Security Number: 214-84-3409
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAR 14 1914
9. Birthplace *(State or Foreign Country)*: SPAIN

Usual Residence of Decedent

10a. State: MD
10b. County: Mont.
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3402 Hewitt Ave
10f. Zip Code: 20906
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): – / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Manuel Rodriguez
18. Mother's Name *(First, Middle, Maiden Surname)*: Maria Enfante

19a. Informant's Name/Relationship *(Type, Print)*: Alberto Gonzalez/ Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3402 Hewitt Avenue, #4, Silver Spring, MD 20906

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc. Date: May 5, 1998
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: MD0689
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

BMW

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular Accident
Due to (or as a consequence of):
b. Thromboembolism
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Atrial Fibrillation
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Insulin Dependent Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: MD 50969
29d. Date signed *(Month, Day, Year)*: April 27, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BULENT ZAIM MD, 11119 ROCKVILLE PIKE, ROCKVILLE MD

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 11 1998
32. Registrar's Signature: Julia Davidson-Randall

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16374

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bonnie Jo Rolland
2. Date of Death Month Day Year: May 10, 1998
3. Time of Death: 11:03 PM
4a. Facility Name *(If not institution, give street and number)*: 1749 Yale Place
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 569-58-2062
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 55 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 20, 1943
9. Birthplace *(State or Foreign Country)*: California

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1749 Yale Place
10f. Zip Code: 20850
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Giva Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elamentary/Secondary (0-12): 12; Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Administrative Assistant
16b. Kind of Business/Industry: Private Secretarial

17. Father's Name *(First, Middle, Last)*: Charles Edward Palmer
18. Mother's Name *(First, Middle, Maiden Surname)*: Laura Elizabeth Pierce

19a. Informant's Name/Relationship *(Type, Print)*: Calvin Charles Rolland, Jr. (husband)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1749 Yale Place, Rockville, MD 20850

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery
Date: 5/13/98
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Steven D Strand
22. Name and Address of Facility: Francis J. Collins Funeral Home, 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Bowel obstruction
Due to (or as a consequence of):
b. Carcinosarcoma of ovary

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of certifier: Albert Steren
29c. License number: D 38682
29d. Date signed *(Month, Day, Year)*: MAY 11, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Albert J. Steren, M.D. 10215 Fernwood RD., Bethesda, MD 20817

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 12 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16375

Certificate of Death

Reg. No.

NAME: REYNARD, HUSTON LUTHER

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Huston Luther Reynard

2. Data of Death Month / Day / Year: May 10, 1998

3. Time of Death: 3:15AM

4a. Facility Name *(If not institution, give street and number)*: Reeder's Memorial Home

4b. City, Town, or Location of Death: Boonsboro

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-09-6601

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Feb. 21, 1910

9. Birthplace *(State or Foreign Country)*: Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Boonsboro

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 141 South Main Street

10f. Zip Code: 21713

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 3 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Molder

16b. Kind of Business/Industry: Mfg.Sandblast Equip

17. Father's Name *(First, Middle, Last)*: Henry Lee Reynard

18. Mother's Name *(First, Middle, Maiden Surname)*: Alice Virginia Sheetz

19a. Informant's Name/Relationship *(Type, Print)*: Earl G. Reynard

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 17550 Swann Road, Hagerstown, Md. 21740

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rest Haven Cemetery | Date: 05-12-98

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: R. Noel Brady

22. Name and Address of Facility: Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cancer of the larynx

Due to (or as a consequence of):

b. Chronic lung disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Alzheimer's Dementia

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: D30584

29d. Date signed *(Month, Day, Year)*: 5/10/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Laurence Greenspoon 130 W High Street, Hancock, MD 21750

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 12 1998

32. Registrar's Signature: Julia Davidson-Rondeau

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 98-16376

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HOWARD LEWIS STRUBLE
2. Date of Death — Month: MAY Day: 7, Year: 1998
3. Time of Death: 7:15pm
4a. Facility Name *(If not institution, give street and number)*: 3027 Millington Rd.
4b. City, Town, or Location of Death: Millington
4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 132-18-4834
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 68 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JAN 8 1930
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: MD.
10b. County: Queen Anne's
10c. City, Town or Location: Millington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3027 Millington Rd.
10f. Zip Code: 21651
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Foreman
16b. Kind of Business/Industry: Lumber Manufacturer

17. Father's Name *(First, Middle, Last)*: Leo Struble
18. Mother's Name *(First, Middle, Maiden Surname)*: Gladys McCoy

19a. Informant's Name/Relationship *(Type, Print)*: Shirley Ransom (friend)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 65 Millington, MD. 21651

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Galena Cemetery — Date: 5/11/98
20c. Location - City or Town, State: Galena, MD.

21. Signature of Funding Service Licensee: [signature] M00510
22. Name and Address of Facility: Galena Funeral Home of Stephen Schaech P.O. Box 235 Galena, MD. 21635

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. colon cancer — 2 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D-13824
29d. Date signed *(Month, Day, Year)*: 5-11-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John C Seymour MD 122 Speer Rd. Chestertown, MD. 21620

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 11 '98
32. Registrar's Signature: [signature] Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16377

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Catherine Sewell
2. Date of Death Month Day Year: April 30, 1998
3. Time of Death: 5:05 p.m.
4a. Facility Name *(If not institution, give street and number)*: Magnolia Hall Nursing Home
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 216-56-1305
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 1, 1905
9. Birthplace *(State or Foreign Country)*: Baltimore, MD

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Rock Hall
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: PO Box 284
10f. Zip Code: 21661
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: James Tracy
18. Mother's Name *(First, Middle, Maiden Surname)*: Clara Moran

19a. Informant's Name/Relationship *(Type, Print)*: Vivian Nordhoff/Grandaughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: PO Box 284 Rock Hall, MD 21661

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Wesley Cemetery — Date: May 4, 1998
20c. Location - City or Town, State: Rock Hall, MD

21. Signature of Funeral Service Licensee: ▶ Kirk A. Helfenbein
22. Name and Address of Facility: Fellows, Helfenbein, & Newnam Funral Home, P.A. 130 Speer Road Chestertown, MD 21620

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. Respiratory failure — 5 days.
Due to (or as a consequence of):
b. Cyclonus Effusion
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Bladder Stones; Dementia; Macular degeneration; Hx TIA; Transient Aphasia Episodes; Osteoporosis Vertebral Compression fx's

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D50996
29d. Date signed *(Month, Day, Year)*: 5/4/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Neil Stoddard 100 Brown St., Chestertown, MD 21620

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 05 '98
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

RKD

98-2660-017

HENRI SOUTHALL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16378

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HENRI ARTHUR JAMES SOUTHALL

2. Date of Death Month: MAY Day: 10, Year: 1998

3. Time of Death: 8:36A.M.

4a. Facility Name *(If not institution, give street and number)*: 6255 BRYAN TOWN DRIVE

4b. City, Town, or Location of Death: BRYANTOWN

4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 220-62-5651

6. Sex: XX M 2☐ F

7. Age *(In yrs. last birthday)*: 42 Yrs. If Under 1 Year Months: Days: If Under 24 Hrs. Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: MAY 21, 1955

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CHARLES

10c. City, Town or Location: BRYANTOWN

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6255 BRYANTOWN DRIVE

10f. Zip Code: 20617

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SERVICE STEAMFITTER

16b. Kind of Business/Industry: HEATING/VENTILATION/AIR

17. Father's Name *(First, Middle, Last)*: RICHARD JUNIOR SOUTHALL

18. Mother's Name *(First, Middle, Maiden Surname)*: ROSE KASSAB

19a. Informant's Name/Relationship *(Type, Print)*: HELEN DENISE SOUTHALL- WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6255 BRYANTOWN DRIVE, BRYANTOWN, MARYLAND 20617

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ST. JOSEPH'S CHURCH CEM.,

Date: MAY 14, 1998

20c. Location - City or Town, State: POMFRET, MD

21. Signature of Funeral Service Licensee: MGB Mark G. Brohawn MARK G. BROHAWN M00053

22. Name and Address of Facility: THE HUNTT FUNERAL HOME, INC. P.O.BOX 156, WALDORF, MARYLAND 20604

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SHOTGUN WOUND OF CHEST

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? INSPECTION 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*: 5-10-98

28b. Time of Injury: 820A M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: SUICIDE BY SHOT SELF.

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: RESIDENCE

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 6255 BRYANTOWN CHARLES CO MD

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Margarita Korell M.D.

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: MAY 11,1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 15 1998

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend #19a, 5/19/98, BMw, Montg.Co.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16379

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
RUTH SLOAN SHIRK	MAY 5, 1998	5:05AM.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ASBURY METHODIST VILLAGE	GAITHERSBURG	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
443-14-7674	1☐M 2☒F	89 Yrs.			6-9-1908	DEWEY, OK.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	MONTGOMERY	GAITHERSBURG	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
211 RUSSELL AVENUE #211	20877	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4YRS	TEACHER	GOVERNMENT

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
W.F. SLOAN	CYNTHIA ANN SMITH

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
CYNTHIA ~~STREETER~~ Streeter (DAUGHTER)	8 RED ROCK ROAD, NEW CITY, NY. 10956

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☐Cremation 3☐Removal from State 4☒Donation 5☐Other (Specify)	GEORGETOWN MED SCH.	5/5/1998	WASHINGTON, DC.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jerry A. Austin	AUSTIN ROYSTER FUNERAL HOME 3821 14TH ST. NW. WASH. D.C. 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic Cardiovascular disease	years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Seizure Disorder

Osteoporosis

Sensory Ataxia

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☑Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Byrl D. Johnson, M.D.	D 19042	MAY 5, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BYRL D. JOHNSON, M.D. 911 Russell Avenue, Gaithersburg, MD 20879

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 11 1998	▶ Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16380

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Irene D. Schoenmann
2. Date of Death (Month, Day, Year): May 11, 1998
3. Time of Death: 1930
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 166-22-3865
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 22, 1928
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5104 Continental Drive
10f. Zip Code: 20853
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrative Assistant
16b. Kind of Business/Industry: National Cathedral School

17. Father's Name (First, Middle, Last): Edward Schnitzel
18. Mother's Name (First, Middle, Maiden Surname): Sara McKay

19a. Interment's Name/Relationship (Type, Print): Sandra I. Schoenmann/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5104 Continental Drive, Rockville, MD 20853

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. Date: May 14, 1998
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: David E. Perry M00803
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. CEREBROVASCULAR ACCIDENT — 14 HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Aheda Ali Khan M.D.
29c. License number: D43323
29d. Date signed (Month, Day, Year): May 13, 1998.

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Aheda Ali Khan, M.D. 18111 PRINCE PHILIP DRIVE SUITE 111, OLNEY MD 20832

State Registrar

31. Date filed (Month, Day, Year): MAY 14 1998
32. Registrar's Signature: Tisha Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16381

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SAMUEL SELSKY
2. Date of Death (Month, Day, Year): MAY 9, 1998
3. Time of Death: 6:53 PM
4a. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-24-1707
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 18, 1913
9. Birthplace (State or Foreign Country): Washington DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1801 E. JEFFERSON STREET #608
10f. Zip Code: 20852
10g. Citizen of What Country?: UNITED STATES
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): REAL ESTATE DEVELOPER
16b. Kind of Business/Industry: PRIVATE INDUSTRY
17. Father's Name (First, Middle, Last): MORRIS SELSKY
18. Mother's Name (First, Middle, Maiden Surname): LENA LAZAROW
19a. Informant's Name/Relationship (Type, Print): PAULA GREENWALD (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11213 FALL RIVER COURT - POTOMAC, MARYLAND 20854
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): KING DAVID MEM. GDNS.
Date: 5/12/98
20c. Location - City or Town, State: FALLS CHURCH, VIRGINIA
21. Signature of Funeral Service Licensee: Robert [illegible]
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

BHW

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiopulmonary Arrest
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Coronary Artery Disease
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cerebrovascular disease
Alzheimers

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] VICTORIA THORNTON, MD
29c. License number: D40453
29d. Date signed (Month, Day, Year): 5/9/98
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VICTORIA THORNTON - 8600 OLD GEORGETOWN ROAD - BETHESDA, MARYLAND 20814

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SAMUEL SELSKY 9:53 PM MAY 9, 1998
Division of Vital Records, P.O. Box 68760,

30

State Registrar

31. Date filed (Month, Day, Year): MAY 15 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16382

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jane N. Shepperd
2. Date of Death Month Day Year: May 7, 1998
3. Time of Death: 5:30AM
4a. Facility Name *(If not institution, give street and number)*: Manor Care - Wheaton
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-20-2999
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 30, 1923
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2919 Burtonhill Drive
10f. Zip Code: 20895
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Librarian/Secretary
16b. Kind of Business/Industry: Johns Hopkins Univ Physic's Lab

17. Father's Name *(First, Middle, Last)*: J. Marion Smith
18. Mother's Name *(First, Middle, Maiden Surname)*: Hannah S. Farley

19a. Informant's Name/Relationship *(Type, Print)*: Irving J. Shepperd (husband)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2919 Burtonhill Drive, Kensington, MD 20895

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Date: 5/7/98
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: William L Boyd
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ARRYTHMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

RENAL FAILURE

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: D35941
29d. Date signed *(Month, Day, Year)*: MAY 7, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PURAN P. MATHUR, #401 50 W. EDMONSTON DR. ROCKVILLE, MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 11 1998
32. Registrar's Signature: Julia Davidson-Randell

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16383

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Frances Skelton
2. Date of Death (Month, Day, Year): May 9, 1998
3. Time of Death: 5:25 AM
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-34-2188
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 6, 1913
9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14400 Homecrest Road, Apt. 225
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Payroll Clerk
16b. Kind of Business/Industry: US Government

17. Father's Name (First, Middle, Last): Joe Dotson
18. Mother's Name (First, Middle, Maiden Surname): Francis Hamrick

19a. Informant's Neme/Reletionship (Type, Print): Mary Jean Ritchey (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12404 Fountain Drive, Clarksburg, MD 20871

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): National Memorial Park | Date: 5/13/98
20c. Locafion - Clty or Town, State: Falls Church, VA

21. Signeture of Funeral Service Licensee: William L Byd
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth): a. ACUTE SUBDURAL HEMATOMA WITH
Due to (or as a consequence of): UNCAL HERMATION — hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Last:
b. Due fo (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
atrial fibrillation
mitral stenosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings aveilable prior fo completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signeture end title of certifier: MD
29c. License number: D38457
29d. Date signed (Month, Day, Year): MAY 9, 1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): N. COHEN MD 1811 Prince Philip Dr, Olney MD 20832

State Registrar

31. Date filed (Month, Day, Year): MAY 12 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 98 16384

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LESLIE STALK
2. Date of Death — Month: 05 Day: 09 Year: 98
3. Time of Death: 10 15 AM
4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 132-09-4147
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Feb. 3, 1916
9. Birthplaca *(Stata or Foraign Country)*: Canada

Usual Rasidance of Decedant

10a. Stata: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Insida City Limits: 1 ☐ Yas 2 ☒ No
10e. Street and Number: 710 Hollywood Ave
10f. Zip Coda: 20904
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Nevar Marriad 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedant Evar in U.S. Armed Forces? 1 ☐ Yas 2 ☒ No — If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.): 1 ☐ Yas 2 ☒ No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedant's Educetion *(Specify only highast greda completed)*: Elamantary/Secondary (0-12): 9 — Collaga (1-4or 5+):
16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use ratirad)*: Iron Worker
16b. Kind of Businass/Industry: Industry

17. Father's Nama *(First, Middla, Last)*: Matthew Stalk
18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Mary Delisle

19a. Infarmant's Name/Raletionship *(Type, Print)*: Jean Bean/Friend
19b. Mailing Addrass *(Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 710 Hollywood Ave, Silver Spring, MD 20904

20a. Mathod of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cemetary, cremetory or othar place)*: Salem Church Cemetery — Data: May 12
20c. Location - City or Town, Stata: Levels, WV

21. Signature of Funaral Service Licensaa: ▶ Alan Donnell
22. Nama and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave, Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the daath. Do not antar the moda of dying, such as cardiac or raspiratory arrast, shock, or haart failu- list only ona causa on aach lina.

		Approximate Interval Between Onset and Death
Immediate Causa (Final disaasa or conditlon rasulting in daath) a.	acute inferior wall myocardial infarction	1 d
Due to (or as a consequence of):		
Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiatad avants rasulting in daath) Last — b.	coronary atherosclerosis	unknown
Due to (or as a consaquance of):		
c.		
Due to (or as a consequance of):		
d.		

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.: aortic stenosis

23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performad? 1 ☐ Yas 2 ☑ No

24b. Wara autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was casa referrad to medical examinar? 1 ☐ Yas 2 ☑ No

26. Placa of Death *(Check only ona)*: Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Othar: 4 ☐ Nursing Home 5 ☐ Rasidanca 6 ☐ Othar *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Panding invastigation 6 ☐ Could not be datarmined

28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Spacify)*
28b. Tima of Injury
28c. Injury at Work? 1 ☐ Yas 2 ☐ No
28d. Describe how injury occurred
28e. Dete of Injury *(Month, Dey Year)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1 ☑ **Certifying Physician**: To tha best of my knowledga, death occurrad at the time, data and placa, and dua to tha cause(s) and manner as stated. 2 ☐ **Medical Examinar**: On tha basis of axaminetion and/or invastigation, in my opinion, death occurrad at tha tima, data and placa, and due to the cause(s) and mannar statad.

29b. Signature and titla of certifiar: ▶ Michael Lincoln MD
29c. Licansa number: D29293
29d. Data signed *(Month, Day, Year)*: 5/9/98

30. Nama and address of person who complatad causa of daath (Item 23a) (Type, Print): Michael Lincoln, MD 10313 Georgia Ave Ste 308 Silver Spring MD 20902

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 11 1998
32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rav 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16385

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILTON M. STEINBAUER

2. Date of Death: Month MAY Day 08 Year 1998

3. Time of Death: 10:10 PM

4a. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 318-01-0196

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 14, 1904

9. Birthplace (State or Foreign Country): Minnesota

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 5421 Wickford Drive

10f. Zip Code: 20852

10g. Citizen of What Country?: Unites States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman

16b. Kind of Business/Industry: Millwork

17. Father's Name (First, Middle, Last): Max Frank Steinbauer

18. Mother's Name (First, Middle, Maiden Surname): Pauline Dorsch

19a. Informant's Name/Relationship (Type, Print): Thomas Steinbauer, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 180 Surrey Lane, Barrington, Illinois 60010-3438

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Mary's Cemetery

Data: May 14, 1998

20c. Location - City or Town, State: Winona, Minnesota

21. Signature of Funeral Service Licensee: Terry M. Issi

22. Name and Address of Facility: DeVol Funeral Home, 10 E. Deer Park Dr., Gaithersburg, MD 20877

BMW

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ASYSTOLE	3 MIN
Due to (or as a consequence of): b.	CARDIO-PULMONARY ARREST	5 MIN
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	ASPIRATION PNEUMONIA	6 DAYS
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: PARKINSONS DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: 015236

29d. Date signed (Month, Day, Year): MAY 09, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARL MARGOLIS, M.D. 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

Steinbauer, Wilton M. 5/8/98 10:10pm

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10

State Registrar

31. Date filed (Month, Day, Year): MAY 11 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16386

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Walter Fritz Stettner	May 11, 1998	8:15 p.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Suburban Hospital	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-44-8988	1☒ M 2☐ F	83 Yrs.			June 28, 1914	Treste, Italy

Usual Residence of Decadent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Bethesda	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5108 Marlyn Drive	20816	U.S.A.

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	Development Agency For International	U.S. Department Of State
	+8		

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Maximillian Stettner	Katherina Zuckerman

19a. Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jean H. Stettner Wife	5108 Marlyn Drive, Bethesda, MD 20816

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Parklawn Memorial Park	5/17/98	Rockville, Maryland

21. Signature of Funeral Service Licensee: ▶ Mark L. Villella

22. Name and Address of Facility: Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue N.W., Washington, D.C. 20016

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Ceuse (Finel disease or condition resulting in death)	a. Arteriosclerosis	
	Due to (or as e consequence of):	
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	b. Hypertension	
	Due to (or as a consequence of):	
	c.	
	Due to (or as e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uaa contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es steted.
2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Irene J Tamagna M.D.	D10933	5-11-98

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Irene G. Tamagna, M.D. 7101 Connecticut Avenue, Chevy Chase, MD 20815

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 14 1998	▶ Julia Davidson-Randell

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Dr. Mayle Released

Stettner, Walter Fritz 5-11-98 8:15 p.m.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16387

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dixie M Saunders

2. Date of Death: Month May Day 9 Year 1998

3. Time of Death: 4:18 PM

4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 218 14 6677

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs. If Under 1 Year: Months Days If Under 24 Hrs.: Hours Min.

8. Date of Birth (Month, Day, Year): May 5 1912

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 14 Nina Court

10f. Zip Code: 20877

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farm Labor

16b. Kind of Business/Industry: Farm

17. Father's Name (First, Middle, Last): Rufus Gray

18. Mother's Name (First, Middle, Maiden Surname): Emma Hawes

19a. Informant's Name/Relationship (Type, Print): Mary A. Saunders / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14 Nina Court, Gaithersburg, Maryland 20877

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other place): Metropolitan Crematory

Date: 5/11/98

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Muriel H. Barber

22. Name and Address of Facility: Muriel H. Barber Funeral Home P.O. Box 5038, Laytonsville, Maryland 20882

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Arrythmia — minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Uterine Cancer — Years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Infarct Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Tammy Tadom

29c. License number: D47402

29d. Date signed (Month, Day, Year): May 09, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Tammy Tadom 9901 Medical Center Drive, Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year): MAY 12 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16388

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frances Jeannette SHAFER

2. Date of Death Month / Day / Year: May 12 1998

3. Time of Death: 2:00 a.m.

4a. Facility Name *(If not institution, give street and number)*: Clearview Nursing Home

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 217-12-2153

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 24 1923

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Williamsport

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9431 Downsville Pike

10f. Zip Code: 21795

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Her own home

17. Father's Name *(First, Middle, Last)*: Walter I. Deibert

18. Mother's Name *(First, Middle, Maiden Surname)*: Beulah Delauter

19a. Informant's Name/Relationship *(Type, Print)*: Charles E. Shafer, Jr. Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9431 Downsville Pike Williamsport, Md. 21795

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rest Haven Cemetery

Date: 5/14/98

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott Minnich

22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Cardiopulmonary arrest — 2 days

Due to (or as a consequence of):

b. Myocardopathy — 3 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Arteriosclerotic Heart Disease — manyyrs

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atril Fibillation

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward Moody MD

29c. License number: D07857

29d. Date signed *(Month, Day, Year)*: 5/12/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. E. B. Moody, 1190 Mt. Aetna Road, Hagerstown, Md. 21740

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 18 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16389

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ETHEL VIOLA TRACEY
2. Dete of Deeth — Month: MAY Dey: 9, Yeer: 1998
3. Time of Deeth: 3:35 AM.
4e. Fecility Neme *(If not institution, give street and number)*: WESTMINSTER NURSING & CONVALESCENT CENTER
4b. City, Town, or Location of Deeth: WESTMINSTER
4c. County of Deeth: CARROLL

Funeral Director

5. Social Security Number: 213-05-1551
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. lest birthday)*: 97 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: 9/24/1900
9. Birthpiece *(State or Foreign Country)*: MARYLAND

Usuel Residence of Decedent

10e. Stete: MD.
10b. County: CARROLL
10c. City, Town or Location: WESTMINSTER
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 729 OLD WESTMINSTER PIKE
10f. Zip Code: 21157
10g. Citizen of Whet Country?: USA.

11. Marital Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - Americen Indien, Bleck, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE
16b. Kind of Business/Industry: HOMEMAKING
17. Fether's Neme *(First, Middle, Last)*: J. JACOB BASLER
18. Mother's Neme *(First, Middle, Meiden Surname)*: LYDIA DRECHSLER
19e. Informent's Neme/Relationship *(Type, Print)*: HELEN L. GREEN - NIECE
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 729 OLD WESTMINSTER PIKE, WESTMINSTER, MD. 21157
20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Pleca of Disposition *(Name of cemetery, crematory or other placa)*: WESTMINSTER CEMETERY
Dete: 5/12/98
20c. Location - City or Town, Stete: WESTMINSTER, MD.
21. Signature of Funeral Service Licensee: Thos Fle
22. Name end Address of Feciliity: FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157

To Be Completed by Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Final diseese or condition resulting in deeth)
e. Atherosclerotic Coronary Vascular Disease — 10 yrs

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert i.

23b. **Did tobacco use contributa to the cause of death?** 1☐ **Yes** 2☑ **No** 3☐ **Probably** 4☐ **Unknown**

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end titie of certifier: Robt L. Moss MD
29c. License number: 032082
29d. Date signed *(Month, Day, Year)*: 5/11/98

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print): Robert L. Moss 114 Business Center Drive Reisterstown, MD 21136

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: MAY 12 1998
32. Registrer's Signature: Julie Davidson Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16390

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: KLARA TABAK
2. Date of Death Month Day Year: MAY 9, 1998
3. Time of Death: 5:10 PM
4a. Facility Name *(If not institution, give street and number)*: HEBREW HOME OF GREATER WASHINGTON
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 133-84-2035
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 31, 1924
9. Birthplace *(State or Foreign Country)*: UKRAINE

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: ☒Yes 2☐ No
10e. Street and Number: 6121 MONTROSE ROAD
10f. Zip Code: 20852
10g. Citizen of What Country?: UKRAINE

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CHEMICAL ENGINEER
16b. Kind of Business/Industry: ENGINEER

17. Father's Name *(First, Middle, Last)*: AVRUM YANUSH POLSKIY
18. Mother's Name *(First, Middle, Maiden Surname)*: ROSE YANUSH POLSKIY

19a. Informant's Name/Relationship *(Type, Print)*: ZOYA BOLGAR-DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 445 W. DIAMOND AVE. GAITHERSBURG, MARYLAND 20877

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CHESED SHEL EMMES
Date: 5-12-98
20c. Location - City or Town, State: CAPITOL HEIGHTS, MD

21. Signature of Funeral Service Licensee: ▶ Robert Levine
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Carcinoma of colon with metastasis to liver — 18 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D23958
29d. Date signed *(Month, Day, Year)*: 5/11/98
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Burt I. Feldman MD, 6105 Montrose Rd., Rockville MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 13 1998
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

JW

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16391

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Cynthia F. Titelman

2. Date of Death Month/Day/Year: May 8, 1998

3. Time of Death: 1:30 PM

4a. Facility Name (If not institution, give street and number): Hebrew Home of Greater Washington D.C.

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 027-07-9970

6. Sax: 1☐M 2☒F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): June 13, 1913

9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Montgomery | 10c. City, Town or Location: Rockville | 10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 6121 Montrose Rd. | 10f. Zip Coda: 20852 | 10g. Citizen of What Country?: USA

11. Marital Status: 1☒Naver Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): self employed

16b. Kind of Business/Industry: retail yarn

17. Fathar's Name (First, Middle, Last): Joseph Titelman

18. Mother's Name (First, Middle, Maiden Surname): Jennie

19a. Informent's Neme/Relationship (Type, Print): Dorothy Isaacson (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5901 Montrose Rd. Rockville, MD 20852

20a. Method of Disposition: 1☐Burial 2☐Cremation 3☒Ramoval from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King Solomon Mem. Park | Date: 5/11/98 | 20c. Location - City or Town, State: W. Roxbury, Mass.

21. Signature of Funeral Service Licensee: Robert Lipson

22. Name and Address of Facility: Danzansky Goldberg Memorial Chapel 1170 Rockville Pike Rockville, MD 20852

To Be Completed by Funeral Director

JW Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. CVA — WEEKS

Due to (or as a consequence of):
b. CEREBROVASCULAR DISEASE — 20 YEARS

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. DIABETES MELLITUS — YEARS

Due to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceusa given in Part I.

PERIPHERAL ARTERIOSCLEROSIS

23b. Did tobacco uee contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Ware autopsy findings availeble prior to completion of ceuse of deeth? 1☐Yes 2☐No

25. Was cese referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Homa 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Tima of Injury M | 28c. injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner es stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: Steven Lipson MD | 29c. Licanse number: D 05885 | 29d. Date signed (Month, Day, Year): 5/8/98

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): STEVEN LIPSON 6121 MONTROSE RD, ROCKVILLE

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAY 13 1998

32. Registrar's Signeture: Julia Davidson-Randell

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16392

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Lillian	C.	Tozzi	May 6, 1998	8:30 PM

4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sunrise of Rockville	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
154-07-6495	1☐ M 2☒ F	79 Yrs.			Dec.22,1918	New Jersey

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Rockville	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8 Baltimore Road #316	20850	United States

11. Meritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specity Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.)	14. Rece - American Indien, Bleck, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
-	3	Registered Nurse	Hospital

17. Fether's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surneme)
Patsy Canfora	Lucy Palumbo

19a. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
James E. Tozzi, M.D./ Son	7001 Natelli Woods Lane, Bethesda, MD 20817

20e. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) / Date	20c. Location - City or Town, Stete
1☐ Burial 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)	May 9, 1998 Montgomery Crematorium, Inc.	Bethesda, Maryland

21. Signeture of Funerel Service Licensee	22. Neme end Address of Facility
M00689	Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert failure. List only one cause on eech line.

		Approximete Interval Between Onset and Deeth
Immediete Cause (Finel diseese or condition resulting in deeth)	e. Metastatic Pancreatic Carcinoma	
	Due to (or es e consequence of):	
Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest	b.	
	Due to (or es e consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed?	24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes cese referred to medicel exeminer?	26. Piece of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth	28e. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.
2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
	D43028	May 8, 1998

30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print)
I. David Shocket, M.D. 106 Irving Street, N.W. Washington, D.C. 20010

State Registrar

31. Dete filed (Month, Day, Yeer)	32. Registrer's Signeture
MAY 11 1998	Julie Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 98 16393

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joseph Allen True
2. Date of Death Month: May Day: 9 Year: 1998
3. Time of Death: 1330
4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 220-80-2227
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 33 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 10, 1964
9. Birthplace *(State or Foreign Country)*: WV

Usual Residance of Decedant

10a. State: MD
10b. County: Washington
10c. City, Town or Location: Hancock
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 13035 Woodmont Road
10f. Zip Coda: 21750
10g. Citizan of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machine Operator
16b. Kind of Business/Industry: Parts Remanufacture

17. Father's Name *(First, Middle, Last)*: Douglas True
18. Mother's Name *(First, Middle, Maiden Surname)*: Betty A. Boden

19a. Informant's Name/Relationship *(Type, Print)*: Betty A. Courtney/Mother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: HCR 80 Box 4 Warfordsburg, PA 17267

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Warfordsburg Presbyterian — Date: 5/12/98
20c. Location - City or Town, State: Warfordsburg, PA 17267

21. Signature of Funeral Service Licensee: Richard S. Grove
22. Name and Address of Facility: Grove Funeral Home, P.A. 141 West Main Street Hancock, MD 21750-0368

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Alcohol withdrawal	2-3 Days
Due to (or as a consequence of): b.	Adult Respiratory Distress Syndrome	1-2 Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Severe Pancreatitis	1 week
Due to (or as a consequence of): d.	Renal Insufficiency	3-4 Days

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypoalbuminemia
Hypertriglyceridemia
Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D46081
29d. Date signed *(Month, Day, Year)*: May 10, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frank J. Collins 346 Mill Street Hagerstown MD 21740

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 13 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

True, Joseph Allen

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16394

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vera Usdin
2. Date of Death (Month, Day, Year): May 09, 1998
3. Time of Death: 2215
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 133-16-3902
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 31, 1925
9. Birthplace (State or Foreign Country): Austria

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6 Stevens Court
10f. Zip Code: 20850
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Scientist
16b. Kind of Business/Industry: Gillette Research Corporation
17. Father's Name (First, Middle, Last): Robert Rudin
18. Mother's Name (First, Middle, Maiden Surname): Natascha Adlersberg
19a. Informant's Name/Relationship (Type, Print): Tommie Usdin/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1714 Tweed Street, Rockville, Maryland 20851
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. Date: May 11, 1998
20c. Location - City or Town, State: Bethesda, Maryland
21. Signature of Funeral Service Licensee: Ronald Fourt M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc 300 West Montgomery Avenue Rockville, Maryland 20850-2805

JW

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Acute Myocardial Infarction — 30 minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: D Soell MD
29c. License number: D46741
29d. Date signed (Month, Day, Year): May 09, 1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Deepak Sachdeva, MD — Shady Grove Adventist Hospital 9901 Medical Center Drive Rockville, Maryland 20850

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAY 14 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16395

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Lest)*: CARLVIN BURTON VANSANT
2. Data of Death Month / Day / Year: MAY 10 1998
3. Time of Death: 2:55 PM
4a. Facility Neme *(If not institution, give street and number)*: MAGNOLIA HALL NURSING CENTER
4b. City, Town, or Location of Death: CHESTERTOWN
4c. County of Deeth: KENT

Funeral Director

5. Social Security Number: 216-09-3964
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 94 Yrs. — If Under 1 Yaar: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Dey, Year)*: MAY 25, 1903
9. Birthpleca *(Stete or Foreign Country)*: MARYLAND

Usuel Residence of Decedent

10a. State: MD
10b. County: KENT
10c. City, Town or Location: CHESTERTOWN
10d. Insida City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 105 MAPLE AVENUE
10f. Zip Code: 21620
10g. Citizen of Whet Country?: U.S.A.

11. Meritei Stetus: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Dacedant Ever in U,S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puerto Ricen, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Rece - American Indian, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highast grade completed)*: Elementery/Secondery (0-12): 8 — College (1-4or 5+): 0
16a. Decedent's Usuel Occupation *(Giva kind of work done during most of working life. DO NOT use ratired)*: FUEL OIL DISTRIBUTOR
16b. Kind of Business/Industry: RETAIL SALES

17. Fether's Neme *(First, Middla, Last)*: HARRY VANSANT
18. Mother's Nema *(First, Middla, Meiden Sumeme)*: MARGARET MIDDLETON

19e. Informant's Name/Reletionship *(Type, Print)*: ANNE B. VANSANT
19b. Mailing Address *(Stret end Number or Rural Route Number, City or Town, Stete, Zip Code)*: P.O. BOX 307 CHESTERTOWN MD. 21620

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Ramoval from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: WESLEY CHAPEL CEMETERY — Date:
20c. Location - City or Town, State: [redacted] ROCK HALL MD.

21. Signature of Funeral Service Licensee: Marvin V. Williams
22. Nama and Address of Fecility: MARVIN V. WILLIAMS JR P O Box 223 CHESTERTOWN, MD 21620

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arreat, shock, or heart feilure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final diseese or condition resulting in deeth) a.	CHRONIC RENAL FAILURE	3 YRS
Due to (or as a consequence of): b.	HYPERTENSION	30 YRS
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Lest — Due to (or es e consequence of): c.		
Due to (or es e consequence of): d.		

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contributs to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings avelieble prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Plece of Deeth *(Check only one)*: Hospitel: 1 [ ] inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined
28e. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner as stated. 2 [ ] **Medical Examiner:** On the besis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and piece, end due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: John C. Seymour MD
29c. License number: D-13824
29d. Dete signed *(Month, Dey, Year)*: 5-11-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN C. SEYMOUR 122 SPEER RD. CHESTERTOWN MD 21620

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 13 '98
32. Registrar's Signature: Julia Davidson-Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16396

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Diana J. Van Hover

2. Date of Death — Month: May Day: 11, Year: 1998

3. Time of Death: 2:40 PM

4a. Facility Name (If not institution, give street and number): 11621 Glen Road

4b. City, Town, or Location of Death: Potomac

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 231-70-7100

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 22, 1921

9. Birthplace (State or Foreign Country): England

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Potomac

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11621 Glen Road

10f. Zip Code: 20854

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Arthur Paget Parker

18. Mother's Name (First, Middle, Maiden Surname): Valerie Joyce Terry

19a. Informant's Name/Relationship (Type, Print): Anthony J. Van Hover/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8209 Stone Trail Drive, Bethesda, Maryland 20817

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. — Date: May 13, 1998

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Michael J. Fuller

22. Name and Address of Facility: M00846 Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Rectal Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dr Michael J Furlong

29c. License number: D 39 838

29d. Date signed (Month, Day, Year): 5-12-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael J. Furlong, M.D., 10810 Connecticut Avenue, Kensington, Maryland 20895

State Registrar

31. Date filed (Month, Day, Year): MAY 14 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16397

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Richard Lloyd Winter

2. Date of Death Month: May Day: 6 Year: 1998

3. Time of Death: 0744

4a. Facility Name *(If not institution, give street and number)*: Kent & Queen Anne's Hospital

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 179-22-4428

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: February 14, 1930

9. Birthplace *(State or Foreign Country)*: Bryn Mawr, PA

Usual Residence of Decedent

10a. State: Maryland

10b. County: Kent

10c. City, Town or Location: Kennedyville

10d. Inside City Limits: 1 [ ] Yes 2 [ ] No

10e. Street and Number: 28428 Spring Road

10f. Zip Code: 21645

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grade completed)*: Elementery/Secondery (0-12): 12 College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Chemical Engineer

16b. Kind of Business/Industry: Chemical Corporation

17. Father's Name *(First, Middle, Last)*: Joseph William Winter

18. Mother's Name *(First, Middle, Maiden Surname)*: Edna Haley Bevan

19a. Informent's Neme/Relationship *(Type, Print)*: Doris Helene Siepmann Winter/Wife

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 28428 Spring Road, Kennedyville, MD 21645

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or othar place)*: Shrewsbury Cemetery

Date: May 9, 1998

20c. Location - City or Town, State: Kennedyville, MD

21. Signature of Funeral Service Licensee: Kirk J. Helfenbein

22. Name and Address of Facility: Fellows, Helfenbein, & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediata Cause (Final diseese or condition resulting in death) a. Acute Myocardial Infarction — Instantly

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to compiation of causa of death? 1 [ ] Yas 2 [ ] No

25. Was cese referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only ona)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Sulcide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 [X] **Medical Examiner:** On the besis of exemination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Harry P Ross, MED Exam

29c. License number: D10001

29d. Date signed *(Month, Day, Year)*: 7 MAY 1998

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print): HARRY P ROSS, 516 WASH. AVE. CHESTERTOWN, MD 21620

State Registrar

31. Data filed *(Month, Day, Year)*: MAY 11 '98

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8 + 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16398

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: James Judson White III

2. Dete of Deeth — Month: May, Dey: 5, Yeer: 1998

3. Time of Deeth: 2:05 p.m.

4e. Feciility Neme *(If not institution, give street end number)*: 24251 Chestertown Road

4b. City, Town, or Locetion of Deeth: Chestertown

4c. County of Deeth: Kent

Funeral Director

5. Sociel Security Number: 217-36-0715

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. lest birthdey)*: 58 Yrs.

If Under 1 Year — Months: Deys: If Under 24 Hrs. — Hours: Min.:

8. Dete of Birth *(Month, Dey, Yeer)*: September 7, 1939

9. Birthplece *(Stete or Foreign Country)*: Wilmington, DE

Usuel Residence of Decedent

10e. Stete: Maryland

10b. County: Kent

10c. City, Town or Locetion: Chestertown,

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 24251 Chestertown Road

10f. Zip Code: 21620

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Rece - Americen Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+): 5+

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Attorney

16b. Kind of Business/Industry: Self Employed

17. Father's Neme *(First, Middle, Last)*: James Judson White, Jr.

18. Mother's Neme *(First, Middle, Meiden Surname)*: Catherine Urie

19e. Informent's Neme/Reletionship *(Type, Print)*: James Judson White, IV/Son

19b. Melling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 113 School Road, Chestertown, MD 21620

20e. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Still Pond Cemetery

Dete: May 9, 1998

20c. Locetion - City or Town, Stete: /Still Pond, MD

21. Signeture of Fuperel Service Licensee: Kirk A. Helfenbein

22. Neme end Address of Facility: Fellows, Helfenbein, & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetion thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth):
e. HEART FAILURE — 1 hr

Due to (or es e consequence of):
b. CARDIOMYOPATHY — 10 yrs

Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest:
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1 [ ] Yes 2 [ ] No

25. Wes cese referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*:

28b. Time of Injury: M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred:

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*:

28f. Locetion *(Street and Number or Rurel Route Number, City or Town, Stete)*:

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medicel Exeminer:** On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Jeb C Seymour MD

29c. License number: D-13224

29d. Dete signed *(Month, Day, Yeer)*: 5-6-98

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): John C. Seymour, MD 122 Speer Road, Chestertown, MD 21620

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: MAY 07 '98

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8 + 1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16399

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carl Kenneth Williams

2. Date of Death: Month: April Day: 30 Year: 1998

3. Time of Death: 1413

4a. Facility Name (If not institution, give street and number): Med Point Nursing & Rehab Ctr.

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 203-07-8903

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 16, 1923

9. Birthplace (State or Foreign Country): Lancaster, PA

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Cecilton

10d. Inside City Limits: 1 [ ] Yes 2 [ ] No

10e. Street and Number: 203 E. Main Street

10f. Zip Code: 21913

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bus Contractor

16b. Kind of Business/Industry: Cecil County Public School

17. Father's Name (First, Middle, Last): Uknown

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Madeline Williams/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 203 E. Main Street PO Box 24 Cecilton, MD 21913

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Zion Cemetery

Date: May 3, 1998

20c. Location - City or Town, State: Cecilton, MD

21. Signature of Funeral Service Licensee: Gary B Fellows

22. Name and Address of Facility: Fellows, Helfenbein, & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Severe Emphysema — 2 yrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Corpulmonale

congestive Heart failure

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

28. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Wallace Obenshain MD

29c. License number: D-07129

29d. Date signed (Month, Day, Year): April 30, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): WALLACE OBENSHAIN, MD. Cecilton, Md. 21913

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10+1

State Registrar

31. Date filed (Month, Day, Year): MAY 05 '98

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16400

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: William Lee Wallace
2. Dete of Death Month / Day / Yeer: May 10, 1998
3. Time of Death: 1:28 AM
4e. Facility Neme *(If not institution, give street and number)*: Suburban Hospital
4b. City, Town, or Location of Deeth: Bethesda
4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 578-42-4173
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 66 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 5, 1931
9. Birthplece *(State or Foreign Country)*: Tennessee

Usual Residence of Decedent

10e. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 10201 Grosvenor Place, #1518
10f. Zip Code: 20852
10g. Citizen of Whet Country?: United States
11. Maritel Stetus: 1 [X] Never Merried 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Yeer or Detes: unavailable
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - Americen Indien, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Financial Officer
16b. Kind of Business/Industry: C. I. A.
17. Fether's Neme *(First, Middle, Last)*: (unavailable) Wallace
18. Mother's Name *(First, Middle, Maiden Surname)*: Genevieve (unavailable)
19e. Informant's Neme/Relationship *(Type, Print)*: Margaret D. Farthing (attorney)
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 200A Monroe Street, #210, Rockville, MD 20850
20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Parklawn Memorial Park
Date: 5-13-98
20c. Location - City or Town, Stete: Rockville, Maryland
21. Signature of Funeral Service Licensee: Ellen L. Rapp
22. Neme and Address of Facility: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in deeth): a. Carcinoma of Rectum — 1 year
Due to (or es e consequence of):
Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in deeth) Lest
b.
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Neuropathy; Diabetes

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No
25. Was cese referred to medical exeminer? 1 [ ] Yes 2 [X] No
26. Piece of Deeth *(Check only one)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28e. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner as steted. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, dete and piece, and due to the cause(s) end menner steted.
29b. Signature and title of certifier: Daniel Rosenblum MD
29c. License number: D04766
29d. Date signed *(Month, Day, Year)*: May 10, 1998
30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print): Daniel Rosenblum, M. D., 10400 Connecticut Avenue, #606, Kensington, MD 20895

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

William Wallace 5-10-98 1:28 Am

6

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 13 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16401

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: JOHN FRANK WATHEN
2. Date of Deeth — Month: MAY — Dey: 6, — Year: 1998
3. Time of Death: 11:05 PM
4a. Facility Neme *(If not institution, give street and number)*: MANOR CARE NURSING HOME
4b. City, Town, or Location of Death: WHEATON
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-56-6450
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 53 Yrs. — If Under 1 Yaar: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: NOV. 27, 1944
9. Birthplece *(State or Foreign Country)*: MARYLAND

Usuel Residence of Decedent

10e. Stete: MD
10b. County: MONTGOMERY
10c. City, Town or Location: GAITHERSBURG
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 7454 BRENISH DRIVE
10f. Zip Code: 20879
10g. Citizen of What Country?: UNITED STATES
11. Maritei Stetus: 1 [ ] Never Merried 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Giva Yeer or Dates:
13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No- If Yes, specity Cuben, Mexican, Puerto Rican, atc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Raca - American Indien, Bleck, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grede completed)* — Elementery/Secondary (0-12): 12 — College (1-4or 5+): 0
16e. Decedent's Usuel Occupetion *(Give kind of work dona during most of working life. DO NOT use retired)*: HAIR STYLIST
16b. Kind of Business/Industry: STYLING
17. Fether's Neme *(First, Middle, Last)*: JOHN WATHEN
18. Mother's Name *(First, Middle, Meiden Sumama)*: MARGARET KING WATHEN
19a. Informent's Neme/Reletionship *(Type, Print)*: STEPHEN WATHEN SON
19b. Mailing Address *(Street end Number or Rural Routa Number, City or Town, Stete, Zip Code)*: 1401 BLAIR MILL ROAD, 3 722 SILVER SPRING, MD 20910
20e. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or othar place)*: GATE OF HEAVEN CEMETERY
Dete: 5/9/98
20c. Location - City or Town, Stete: SILVER SPRING, MD
21. Signature of Funeral Servica Licensee: [signature]
22. Name and Addrass of Facility: HINES-RINALDI FUNERAL HOME, 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MARYLAND

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximate Intervel Between Onset end Death
Immediete Ceuse (Finel diseese or condition resulting in deeth) e.	GALL BLADDER CANCER	6 MONTHS
Due to (or es e consequence of):		
Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Last — b.		
Due to (or es e consequence of):		
c.		
Dua to (or es a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveileble prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medicai exeminer? 1 [ ] Yes 2 [X] No

26. Piece of Deeth *(Check only one)*: Hospitei: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Neturei 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Piece of injury - At homa, farm, straet, factory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end pleca, end due to the cause(s) end menner as stated. 2 [ ] **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end pleca, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: [signature]
29c. Licansa number: D42578
29d. Data signed *(Month, Day, Year)*: MAY 8, 1998

30. Nema and eddress of person who completed cause of deeth (item 23e) (Type, Print): DR. GUL CHABLANI 11119 ROCKVILLE PIKE, ROCKVILLE, MD

State Registrar

31. Dete filed *(Month, Dey, Year)*: MAY 11 1998
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Blend

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16402

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROSE E. WEISS
2. Date of Death (Month, Day, Year): MAY 9, 1998
3. Time of Death: 11:00AM
4a. Facility Name *(If not institution, give street and number)*: MANOR CARE - SILVER SPRING
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 224-50-3530
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 04.15.1909
9. Birthplace *(State or Foreign Country)*: VIRGINIA

Usual Residence of Decedent

10e. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2501 MUSGROVE ROAD
10f. Zip Code: 20904
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SECRATARY
16b. Kind of Business/Industry: PRIVATE

17. Father's Name *(First, Middle, Last)*: ELIAS ERLACH
18. Mother's Name *(First, Middle, Maiden Surname)*: LENA KLEINMAN

19a. Informant's Name/Relationship *(Type, Print)*: MINA SMITH/DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12912 MIDDLEVALE LANE, SILVER SPRING, MD 20906

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: FOREST LAWN CEMETERY
Date: 5/11/98
20c. Location - City or Town, State: NORFOLK, VIRGINIA

21. Signature of Funeral Service Licensee: DANIEL SIMONS
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jenny Y Moy MD
29c. License number: D43260
29d. Date signed *(Month, Day, Year)*: May 9, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jenny Y. Moy, MD 13952 Baltimore Ave Laurel MD 20707

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 11 1998
32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16403

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGIE WHITE
2. Date of Death — Month: MAY Day: 07 Year: 1998
3. Time of Death: 11:40 A
4a. Facility Name *(If not institution, give street and number)*: Bon Secours Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 215-32-0151
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 100 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr. 10, 1898
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Highland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 13242 Highland Road,
10f. Zip Code: 20777
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 5th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Domestic
16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Alexander Hebron
18. Mother's Name *(First, Middle, Meiden Surneme)*: Laura Greenfield

19a. Informant's Name/Relationship *(Type, Print)*: Margie Smith (God-daughter)
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 13242 Highland Rd., Highland, MD 20777

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Hopkins Church Cem. — Dete: 5/15/98
20c. Location - City or Town, State: Highland, MD

21. Signeture of Funeral Service Licensee: George R. Snowden
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in deeth)
a. ACUTE PULMONARY EMBOLISM — FEW HOURS
Due to (or as a consequence of):
b. SENILE DEMENTIA — MANY YEARS
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in deeth) Last
Due to (or es e consequence of):
c. STATOS RIGHT BELOW KNEE AMPUTATION — 2 WEEKS
Due to (or es e consequence of):
d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☐ No 3☐ **Probably** 4☑ **Unknown**

24a. Wes an eutopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No
26. Place of Death *(Check only one)* — Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☑ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)* 1☑ **Certifying Phyeicien**: To the best of my knowledge, death occurred at the time, dete and piece, end due to the ceuse(s) end manner es steted. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: B Gonzalez JrMD
29c. License number: D18711
29d. Dete signed *(Month, Dey Year)*: MAY 08 98

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): BERNARDO J. GONZALAS JR, MD, 3000 W. BALTIMORE ST BALT. MD 21223

State Registrar

31. Date filed *(Month, Dey, Year)*: MAY 13 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16404

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: Shirley I. Williams

2. Data of Deeth — Month: May; Day: 9; Year: 1998

3. Time of Death: 8:58 PM

4a. Facility Name *(If not institution, giva street and number)*: Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-46-2180

6. Sax: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 63 Yrs.

If Under 1 Yaar — Months: ; Days:

If Undar 24 Hrs. — Hours: ; Min.:

8. Data of Birth *(Month, Day, Year)*: Sept.6,1934

9. Birthplaca *(State or Foreign Country)*: Wash. DC

Usuel Rasidance of Decedant

10a. Stata: N/A

10b. County: N/A

10c. City, Town or Location: Washington, DC

10d. Inside City Limits: ☒ Yas 2☐ No

10e. Street end Number: 35 Sherman Circle, NW

10f. Zip Code: 20011

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Dacedent Evar in U.S. Armed Forcas? 1☐ Yas ☒ No If Yas, Give Yaar or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Raca - American Indian, Black, Whita, etc. *Specify:* Black

15. Decedant's Educetion *(Specify only highast grada completed)*: Elamentery/Secondary (0-12): 12th; Collega (1-4or 5+):

16a. Decedant's Usual Occupation *(Give kind of work dona during most of working life. DO NOT usa ratired)*: Clerk

16b. Kind of Businass/Industry: U.S. Government

17. Fathar's Name *(First, Middla, Last)*: Albert Beckham

18. Mothar's Nama *(First, Middla, Maiden Sumama)*: Barbara Brannum

19a. Informant's Name/Reletionship *(Type, Print)*: Vincent A. Williams (Son)

19b. Meiling Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 8803 Hunting Lane, Laurel, Md #203 20708

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, crematory or othar place)*: Md. Nat'l Memorial Pk

Dete: 5/15/98

20c. Locatlon - City or Town, State: Laurel, MD

21. Signature of Funaral Service Licensaa: George R. Snowden

22. Nama and Address of Facility: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

JW

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complications that caused tha daath. Do not antar tha moda of dying, such es cerdiac or raspiratory arrast, shock, or heert failura. List only one cause on aach lina.

Approximate Interval Between Onset end Death

Immediate Causa (Final disaasa or condition resulting in deeth)

e. Cardiac arrhythemia — 30-45 mins

Dua to (or as e consequence of):

b. Coronary artery disease — 5 days

Sequantially list conditions, if any, leading to immedieta cause. Entar Underlying Causa (Disaase or Injury that initiated events resulting in daath) Last

Dua to (or as a consequance of):

c. Hypertension — 5 days

Dua to (or as a consequance of):

d. Multiple brain infarcts

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

Bilateral Sphenoidal Sinusitis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy parformed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availeble prior to completion of cause of deeth? 1☐ Yas 2☐ No

25. Was casa rafarred to medical examinar? 1☐ Yas 2☒ No

26. Place of Deeth *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Rasidence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Place of Injury - At home, farm, street, factory, office building, atc. *(Specify)*

28b. Tima of Injury: M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Data of Injury *(Month, Day Yaar)*

28f. Location *(Streat and Number or Rural Route Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledge, daath occurred at the tima, data and place, and dua to the cause(s) and mannar as stated. 2☐ **Medical Examinar**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, deta and place, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of certifier: Rreelapi MD

29c. Licanse number: D24174

29d. Deta signed *(Month, Day, Yaar)*: 5/10/98

30. Nama and addrass of person who complated cause of daath (Item 23a) (Type, Print): PADMAJA S. UDAPI 7350 VAN DUSEN ROAD SUITE 380 LAUREL MD. 20707

To the Hospital or Attending Physician: The law requires that tha daath certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by tha attending physician and completely filled in by tha funeral director, page 2 should be datached for use as tha burial-transit

2

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Data filed *(Month, Day, Yaar)*: MAY 13 1998

32. Registrar's Signatura: Julia Davidson-Randell

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16405

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Helen	G.	Wisor	May 12, 1998	12:45AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
5402 Parkvale Terrace	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
199-16-8373	1☐ M 2☒ F	73 Yrs.			Dec. 22, 1924	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Rockville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5402 Parkvale Terrace	20853	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Loan Officer	Banking

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
Irvin Sylvester Graff	Catherine Swaney

19a. Informant's Name/Relationship (Type, Pnint)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
Joseph S. Wisor, Sr. (husband)	5402 Parkvale Terrace, Rockville, MD 20853

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment	Gate of Heaven Cemetery	5/15/98	Silver Spring, MD

21. Signature of Funeral Service Licensee	22. Neme end Address of Facility
▶ James H Stein Jr	Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. papillary maxillary sinus carcinoma	2yrs, 9 mos.
	Due to (or as a consequence of):	
Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as e consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were sutopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and piace, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ George A Sotos	D38588	05-14-98

30. Name and address of person who completed cause of death (item 23a) (Type, Print)
George Sotos 9707 Medical Center Dr #300 Rockville Maryland 20850

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
MAY 15 1998	▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16406

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Doris B. Wolfrey

2. Date of Death — Month: May Day: 7 Year: 1998

3. Time of Death: 10:20 a.m.

4a. Facility Name (If not institution, give street and number): 7274 Meadow Wood Way

4b. City, Town, or Location of Death: Clarksville

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 217-36-9642

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 57 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 8 1940

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Clarksville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7274 Meadow Wood Way

10f. Zip Code: 21029

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chief Financial Officer

16b. Kind of Business/Industry: Finance-Union

17. Father's Name (First, Middle, Last): Arthur Becraft

18. Mother's Name (First, Middle, Maiden Surname): Ruth Smith

19a. Informant's Name/Relationship (Type, Print): Vernon Craven Wolfrey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7274 Meadow Wood Way, Clarksville, Md. 21029

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Union Cemetery

Date: 5-13-98

20c. Location - City or Town, State: Burtonsville, Md.

21. Signature of Funeral Service Licensee: Dani L. Holland

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, Maryland 20904

JW

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: MD 18320

29d. Date signed (Month, Day, Year): 5/7/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Fahey MD. Johns Hopkins Oncology Center Baltimore MD 21287.

State Registrar

31. Date filed (Month, Day, Year): MAY 13 1998

32. Registrar's Signature: Julia Davidson-Randall

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16407

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Roger Owen WHITMORE , Sr.

2. Date of Death — Month: May Day: 7 Year: 1998

3. Time of Death: 9:15 p.m.

4a. Facility Name *(If not institution, give street and number)*: 11618 St. Pauls Road

4b. City, Town, or Location of Death: Clear Spring

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 219-34-5194

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 60 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: April 2 1938

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Clear Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 11618 St. Pauls Road

10f. Zip Code: 21722

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 10

College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Steel Fabricator

16b. Kind of Business/Industry: Door Company

17. Father's Name *(First, Middle, Last)*: Cyrus Andrew Whitmore

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Shank

19a. Informant's Name/Relationship *(Type, Print)*: Elsie Whitmore - Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11618 St. Pauls Road Clear Spring, Maryland 21722

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Lawn Memorial Park

Date: 5/11/98

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Robert L. Haines

22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. lung cancer	9 months
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Brain Metastasis

Bone Metastasis

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Hind Hamdan, MD

29c. License number: D46473

29d. Date signed *(Month, Day, Year)*: 5/8/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hind Hamdan, MD; 363 S. Cleveland Ave; Hagerstown, MD 21740

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 08 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

98-2633-031

JOHN B. YELTON
ASP

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

98 16408

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John Bruce Yelton

2. Date of Death Month / Day / Year: MAY 09 1998

3. Time of Death: 3:10 A

4a. Facility Name *(If not institution, give street and number)*: 5104 WOODBINE RD.

4b. City, Town, or Location of Death: WOODBINE

4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 212-04-2338

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 26 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 4, 1971

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 2125 W. Old Liberty Road

10f. Zip Code: 21157

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Bricklayer

16b. Kind of Business/Industry: Concrete Co.

17. Father's Name *(First, Middle, Last)*: J.B. Yelton

18. Mother's Name *(First, Middle, Maiden Surname)*: Susan A. Meyd

19a. Informant's Name/Relationship *(Type, Print)*: Susan A. Scheufele Mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4263 Jim Bowers Road Sykesville, MD 21784

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Pleasant Ridge Cemetery Date: May 12

20c. Location - City or Town, State: Woodbine, Maryland

21. Signature of Funeral Service Licensee: James B Coveny

22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? ☒ Yes 2 ☐ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other *(Specify)* ROADWAY

27. Manner of Death: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*: 5/9/98

28b. Time of Injury: 0216 M

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred: Passenger in auto accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: STREET

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 5104 Woodbine RD

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Aaron Locke MD

29c. License number: O.C.M.E

29d. Date signed *(Month, Day, Year)*: MAY 09, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JLARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 12 1998

32. Registrar's Signature: Julia Sheridan Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16409

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CECILIA YOSPY

2. Date of Death — Month: MAY Day: 13 Year: 1998

3. Time of Death: 12 NOON

4a. Facility Name (If not institution, give street and number): Hebrew Home of Greater WASHINGTON 6121 Montrose Rd

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 217-56-7356

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 4 15 07

9. Birthplace (State or Foreign Country): MD

Usual Residance of Dacedant

10a. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 6121 Montrose Rd.

10f. Zip Code: 20852

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas: XX

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Rece - Americen Indian, Black, Whita, atc. Specify: White

15. Dacedent's Education (Specify only highest grede completed): Elemantary/Secondary (0-12): 12 Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Fathar's Nama (First, Middle, Last): Ellis Paul

18. Mothar's Nema (First, Middle, Meiden Sumame): Ida Unknown

19a. Informant's Name/Relationship (Type, Print): Elaine Lessenco/Daughter

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 10731 Gloxinia Dr. Rockville, MD 20852

20a. Method of Disposition: 1☐ Burial 2☑ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Northern Va Crematory Data: 5/14/98

20c. Location - City or Town, Stata: Arlington, VA

21. Signature of Funeral Service Licensee

22. Name end Address of Facility: Ives-Pearson Funeral Home 2847 Wilson Blvd. Arlington, VA 22201

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that ceusad tha daath. Do not antar tha moda of dying, such as cerdiec or raspiratory arrest, shock, or heart failura. List only ona causa on aach lina.

Approximata Intarval Batween Onset end Deeth

Immediate Cause (Final disease or condition resulting in death) a. CEREBRO VASCULAR ACCIDENT — 1 DAY

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Dua to (or as a consequance of):

c.

Due to (or as a consequance of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

ATHEROSCLEROSIS

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☑ No

24b. Ware autopsy findings available prior to complation of cause of daath? 1☐ Yas 2☐ No

25. Was cesa rafarrad to medical examinar? 1☐ Yas 2☑ No

26. Placa of Daath (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Rasidanca 6☐ Othar (Specify)

27. Mannar of Death: 1☑ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Dey Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascriba how injury occurred

28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Cartifier (Check only one) 1☑ Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to tha cause(s) end manner as stated. 2☐ Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha time, date and place, and due to tha cause(s) and mannar statad.

29b. Signatura and title of certifiar: P. Talwar MD.

29c. Licansa number: D36552

29d. Date signed (Month, Day, Year): MAY 13 1998

30. Neme and address of person who complated causa of death (Item 23a) (Type, Print): P. TALWAR 6121 Montrose Road Rockville MD. 20852

State Registrar

31. Data filad (Month, Dey, Yeer): MAY 15 1998

32. Ragistrar's Signatura: Judith Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16410

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Herbert D. Young
2. Date of Death (Month, Day, Year): May 12, 1998
3. Time of Death: 10:35 AM
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-38-5465
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 66 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 29, 1931
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3206 Blueford Road
10f. Zip Code: 20895
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Lead Man
16b. Kind of Business/Industry: PEPCO

17. Father's Name *(First, Middle, Last)*: Arnold Yanovich
18. Mother's Name *(First, Middle, Maiden Surname)*: Esther Barr

19a. Informant's Name/Relationship *(Type, Print)*: Margaret M. Young (wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3206 Blueford Road, Kensington, MD 20895

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery — Date: 5/15/98
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: ▶ Steven O Strand
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

JW

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only *one* cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Metastatic Small cell lung cancer — ONE YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Pneumonia.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: ▶ [signature]
29c. License number: D-33224
29d. Date signed *(Month, Day, Year)*: MAY 12, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAM TREHAN MD 5010 EDMONSTON DR. ROCKVILLE MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 13 1998
32. Registrar's Signature: ▶ Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10+1

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16411

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Paul Young
2. Date of Death (Month, Day, Year): May 10, 1998
3. Time of Death: 4:08 AM
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 208-12-0524
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 6, 1923
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9707 Old Georgetown Road #1416
10f. Zip Code: 20814
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Chinese

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Howard Young
18. Mother's Name (First, Middle, Meiden Surneme): Nellie Tang

19a. Informant's Name/Relationship (Type, Print): Fannie Lee Young/Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 9707 Old Georgetown Rd. #1416, Bethesda, MD 20814

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Pieca of Disposition (Neme of cemetery, crematory or other piece): Oakland Cemetery — Dete: May 13, 1998
20c. Location - City or Town, Stete: West Chester, PA

21. Signature of Funeral Service Licensee: Ray Fair M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Young, Paul May 10, 1998 0408

36+1

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. — Approximete Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death): a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last:
b. DIABETES MELITIS
Due to (or es a consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D26259
29d. Date signed (Month, Dey, Year): 5/11/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ava A. Kaufman, M.D. 4930 Del Ray Avenue, Bethesda, Maryland 20814

State Registrar

31. Dete filed (Month, Day, Yeer): MAY 14 1998
32. Registrar's Signature: Julia Davidson-Randell

DHMH 16 Rev 6/95

98-2563-043
jhm
ROBERT LYNN YOUNG

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 16412 Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert Lynn YOUNG
2. Date of Death Month Day Year: MAY 6, 1998
3. Time of Death: 06:21 AM
4a. Facility Name *(If not institution, give street and number)*: ROUTE 66
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 201-46-6076
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 43 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 12 1955
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Smithsburg
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 8 Pennsylvania Avenue
10f. Zip Code: 21783
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armad Forcas? 1 [ ] Yes 2 [X] No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest greda completed)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+): 5
16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: Supervisor
16b. Kind of Business/Industry: Distribution Center

17. Father's Name *(First, Middle, Last)*: Elmer M. Young
18. Mother's Name *(First, Middle, Meiden Surneme)*: Janet Harmon

19a. Informant's Name/Relationship *(Type, Print)*: Sharon K. Young Wife
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: P.O. Box 460 Smithsburg, Md. 21783

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Piaca of Disposition *(Neme of cemetery, cremetory or other place)*: Hagerstown Crematory — Date: 5-7-98
20c. Location - City or Town, Stata: Hagerstown, Maryland

21. Signature of Funeral Servica Licansee: Scott M Minnich
22. Name and Addrass of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line. — Approximete Interval Between Onset and Deeth

Immediate Ceuse (Finei disaase or condition resulting in death): a. MULTIPLE INJURIES
Due to (or es a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequenca of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [✓] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* SCENE

27. Manner of Death: 1 [ ] Netural 2 [✓] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28e. Date of Injury *(Month, Dey Yeer)*: 5-6-98
28b. Time of Injury: 0735AM
28c. injury at Work? 1 [ ] Yes 2 [✓] No
28d. Describe how Injury occurred: WITH PICKUP DRIVER OF CAR IN COLLISION
28a. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*: ROADWAY
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*: RT 66 WASHINGTON CO MD

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To tha best of my knowledge, death occurred at the time, date and place, and dua to tha causa(s) and manner as stated. [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and titie of certifier: Marjorie Bollinger
29c. Licansa number: OCME
29d. Date signed *(Month, Dey, Year)*: MAY 6, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARJORIE A. BOLLINGER MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 08 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16413

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jeanne E. Zimmerman
2. Date of Death Month Day Year: May 10, 1998
3. Time of Death: 10:10 PM
4a. Facility Name *(If not institution, give street and number)*: 800 Gail Avenue
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218-12-8936
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Yaar)*: Dec. 27, 1921
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 800 Gail Avenue
10f. Zip Code: 20851
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowad 4☐ Divorced
12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Raca - Amaricen Indian, Black, White, etc. *Specify:* White
15. Decedent's Educetion *(Specify only highest grada completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 1
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind ot Business/Industry: Own Home
17. Father's Nema *(First, Middle, Last)*: Edward Clarence Hawkins
18. Mother's Nama *(First, Middle, Maiden Surneme)*: Mary Lou Hutton
19a. Intormant's Name/Relationship *(Type, Print)*: Louis L. Zimmerman/Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 800 Gail Avenue, Rockville, Maryland 20851
20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Placa ot Disposition *(Name of cemetery, crematory or othar place)*: Parklawn Memorial Park — Date: May 14, 1998
20c. Location - City or Town, Stata: Rockville, Maryland
21. Signature of Funaral Service Licensee: ▶ [signature] MD1126
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

JW

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or hiart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death):
a. Breast Cancer
Due to (or es e consequence ot):
b. Osteoporosis

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
c. Anxiety
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceuse givan in Part I.

23b. Did tobacco use contributa to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy tindings available prior to completion ot cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicel exeminer? 1☒ Yes 2☐ No

26. Place ot Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner ot Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best ot my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and menner stated.

29b. Signatura and titia of certifier: ▶ [signature] MD
29c. Licansa number: D43272
29d. Date signed *(Month, Day, Year)*: May 11, 1998

30. Name and address ot person who completed cause of death (Item 23a) (Type, Print): Sunita Hanjura, M.D., 809 Veirs Mill Road, #101, Rockville, Maryland 20851-1689

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State Registrar

31. Date tiled *(Month, Dey, Year)*: MAY 14 1998
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16414

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: Jeanne Zatman

2. Date of Deeth — Month: May; Dey: 12; Yeer: 1998

3. Time of Deeth: 4:15pm

4e. Facility Name *(If not institution, give straet and number)*: Hebrew Home of Greater Washington

4b. City, Town, or Location of Death: Rockville

4c. County of Deeth: Montgomery

Funeral Director

5. Sociel Security Numbar: 579-05-7357

6. Sax: 1☐M 2☒F

7. Age *(In yrs. lest birthday)*: 82 Yrs.

If Under 1 Yaar — Months: ; Deys:

If Under 24 Hrs. — Hours: ; Min.:

8. Dete of Birth *(Month, Dey, Yeer)*: Aug. 15, 1915

9. Birthpleca *(Stata or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street end Number: 6125 Montrose Rd.

10f. Zip Code: 20852

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Stetus: 1☐Never Marriad 2☐Married 3☐Widowed 4☒Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yaar or Detes:

13. Was Dacedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexicen, Puarto Rican, etc.): 1☐Yes 2☒No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+):

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales

16b. Kind of Business/Industry: Dept. Store

17. Fether's Neme *(First, Middle, Last)*: Simon Leipziger

18. Mother's Name *(First, Middle, Meiden Surneme)*: Rose Asher

19e. Informent's Neme/Reletionship *(Type, Print)*: Eric Zatman/Son

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 43 Appleseed Lane Gaithersburg, MD 20878

20e. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Removal from State 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Judean Mem. Gdns.

Dete: 5/14/98

20c. Location - City or Town, Stete: Olney, MD

21. Signature of Funaral Service Licensee: Emma K. Newlon

22. Name end Address of Facility: Ives-Pearson Funeral Home 2847 Wilson Blvd. Arlington, VA 22201

BMW

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Pert1. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiac or raspiretory errast, shock, or hevrt feilure. List only one ceuse on eech line.

Approximete intervel Between Onset end Death

Immediate Ceuse (Finel disaase or condition resulting in death): e. Pneumonia — 3 hours

Due to (or es e consequence of): b. Dementia — Years

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseesa or injury thet initieted events resulting in deeth) Lest: c. Parkinson's disease — Years

Dua to (or es e consequanca of): d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Arteriosclerotic heart disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Wes en autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings aveilable prior to completion of ceuse of death? 1☐Yes 2☐No

25. Wes cese referred to medicel exeminer? 1☐Yes 2☒No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐inpatient 2☐ER/Outpetient 3☐DOA Other: 4☒Nursing Homa 5☐Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Invastigation 6☐Could not be determined

28a. Dete of injury *(Month, Dey Yeer)*:

28b. Time of injury:

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred:

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*:

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*:

29e. Certifier *(Check only one)*: 1☒**Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐**Medical Exemfner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred at the time, dete end place, end due to the ceuse(s) end manner stated.

29b. Signetura and title of certifier: Bert I. Feldman MD

29c. License number: D23958

29d. Date signed *(Month, Dey, Yeer)*: 5/12/98

30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): Bert I. Feldman, MD, 6105 Montrose Rd., Rockville MD 20852

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State Registrar

31. Dete filed *(Month, Day, Yeer)*: MAY 15 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16415

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: KATHERINE BERTHA ZIMMERMANN

2. Data of Death Month: MAY Day: 12, Yaar: 1998

3. Tima of Death: 9:20 PM

4a. Facility Nama *(If not institution, giva street and number)*: BROOKE GROVE NURSING CENTER

4b. City, Town, or Location of Death: SANDY SPRINGS

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 229-44-8803

6. Sax: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 99 Yrs. If Under 1 Yaar: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: JULY 7, 1898

9. Birthplace *(State or Foraign Country)*: SWITZERLAND

Usual Rasidance of Decedant

10a. Stata: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: SANDY SPRINGS

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 18430 BROOKE GROVE ROAD

10f. Zip Coda: 20860

10g. Citizan of What Country?: UNITED STATES

11. Marital Status: 1☐ Navar Marriad 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armad Forcas? 1☐ Yas 2☒ No. If Yas, Giva Yaar or Datas:

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* CAUCASIAN

15. Decedant's Education *(Specify only highast grada complatad)*: Elamentary/Secondary (0-12): 8; Collaga (1-4or 5+):

16a. Decedant's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT usa retired)*: OWNER

16b. Kind of Businass/Industry: SWISS HAND LAUNDRY

17. Fathar's Nama *(First, Middla, Last)*: ALOIS SIDLER

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: KATHARINA INEICHEN

19a. Informant's Name/Ralationship *(Typa, Print)*: HARRY ZIMMERMANN

19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 4508 KLING DRIVE, ALEXANDRIA, VIRGINIA 22312

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of camatary, cramatory or othar placa)*: FAIRFAX MEM. PARK

Data: 5/15/98

20c. Location - City or Town, Stata: FAIRFAX, VIRIGNIA

21. Signature of Funaral Sarvica Licansaa: Robert J. Murphy, CFSP

22. Nama and Addrass of Facility: ROBERT J. MURPHY FUNERAL HOME, INC. 4510 WILSON BLVD. ARL. VA. 22203

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

BLW

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediata Causa (Final disaasa or condition rasulting in daath)

a. ASPIRATION PNEUMONIA — 18 HOURS

Due to (or as a consequanca of):

Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Ceuse (Disaasa or injury thet initieted evants rasulting in death) Last

b.

Due to (or as a consequance of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to daath but not resulting in tha underlying causa givan in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy parformed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of causa of deeth? 1☐ Yas 2☐ No

25. Was case rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☒ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not ba datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, street, factory, offica building, atc. *(Spacify)*

28f. Location *(Streat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledga, daath occurrad at tha time, data and placa, and dua to tha causa(s) and manner as statad. 2☐ **Medical Examinar**: On tha basis of axamination and/or investigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and manner stated.

29b. Signature and title of cartifiar: T E Howe.

29c. Licansa number: D33700

29d. Data signed *(Month, Day, Yaar)*: MAY 13, 1998

30. Nama and addrass of parson who compiatad cause of death (Itam 23a) (Type, Print): TED E. HOWE 7542 OVERLOOK DR. BOONSBORO, MD 21713

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

State Registrar

31. Data filed *(Month, Day, Yaar)*: MAY 15 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16416

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CORNELIUS ALLEN
2. Date of Death Month Day Year: 5/16/98
3. Time of Death: 4;30AM
4a. Facility Name *(If not institution, give street and number)*: SANDTOWN WINSHESTER NURSING HOME
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 224 38 9973
6. Sex: 1 # M 2 ☐ F
7. Age *(In yrs. last birthday)*: 66 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 9/26/34
9. Birthplace *(State or Foreign Country)*: VA.

Usual Residence of Decedant

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: # ☐ Yes 2 ☐ No
10e. Street and Number: 11 WEST 20th STREET
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ # Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes # ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 # No Specify:
14. Race - American Indian, Black, White, etc. Specify: AFRO AMERICAN

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: laborer
16b. Kind of Business/Industry: PRIVATE CO.

17. Father's Name *(First, Middle, Last)*: unknown
18. Mother's Name *(First, Middle, Maiden Surname)*: unknown

19a. Informant's Name/Relationship *(Type, Print)*: LENA BROWN FRIEND
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1001 BETHUNE RD. BALTO. MD. 21225

20a. Method of Disposition: 1 # Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: MT. ZION CEM.
Date: 5/21/98
20c. Location - City or Town, State: LANSDOWNE, MD.

21. Signature of Funeral Service Licensee: ▶ Earl A Estep
22. Name and Address of Facility: ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):
b. Deabetes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cerebra Vascular Accident
Hypertension
History of Decubetes Ulcer

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residance 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Anil Uberoi MD
29c. License number: D26748
29d. Date signed *(Month, Day, Year)*: 5/20/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANIL UBEROI MD 4419 FALLS RD BALTOMD 21211

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1998
Registrar's Signature: ▶

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16417

Physician /Medical Examiner

1. Decedant's Name *(First, Middle, Last)*	2. Data of Death Month / Day / Yaar	3. Time of Death
THOMAS W. ANDERSON	MAY 21, 1998	2:45 PM.

4a Facility Name *(If not institution, give street and number)*	4b. City, Town, or Location of Death	4c. County of Death
CROMWELL NURSING CENTER	PARKVILLE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age *(In yrs. last birthday)*	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth *(Month, Day, Year)*	9. Birthplace *(State or Foreign Country)*
215-24-1943	XX 1 M 2 F	77 Yrs.			07-28-1920	ENGLAND

Usual Residence of Decedent

10a. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A	BALTIMORE CITY	XX Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3833 MONTERERY ROAD	21218	U.S.A.

11. Marital Status	12. Was Decedant Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1 Navar Married XX Married 3 Widowed 4 Divorced	1 Yes XX No If Yes, Give Yeer or Detes:	1 Yes XX No *Specify:*	*Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*		16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4 YEARS	STATIONERY ENGINEER	MANUFACTURING COMPANY

17. Father's Name *(First, Middle, Last)*	18. Mother's Name *(First, Middle, Meiden Surneme)*
ALEXANDER PATTERSON ANDERSON	GRACE FOSTER

19a. Informant's Name/Relationship *(Type, Print)*	19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*
MARY B. ANDERSON (WIFE)	3833 MONTEREY RD., BALTIMORE, MARYLAND, 21218

20a. Method of Disposition	20b. Place of Disposition *(Name of cemetery, crematory or other place)*	Date	20c. Location - City or Town, State
XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other *(Specify)*	ST. STANISLAUS CEM.	5-26	BALTIMORE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ R. H. Ruth	HENRY W. JENKINS AND SONS COMPANY 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Ceuse (Finel disaase or condition resulting in death)	a. Ischemic Heart Disease	YEARS
	Due to (or es e consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	b. Chronic Obstructive Lung Disease	"
	Due to (or es a consequenca of):	
	c. Emphysema	"
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Hypothyrodism

23b. Did tobacco uae contribute to the cause of death? 1 XX Yes 2 No 3 Probably 4 Unknown

24a. Was en autopsy performed?	24b. Were autopsy findings availeble prior to completion of causa of death?
1 Yes XX No	1 Yes 2 No

25. Wes case referred to medical exeminer?	26. Piece of Death *(Check only one)*	
1 Yes XX No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: XX Nursing Home 5 Residenca 8 Other *(Specify)*

27. Mannar of Deeth	28a. Date of Injury *(Month, Day Year)*	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
XX 1 Naturel 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At homa, farm, streat, factory, office building, etc. *(Specify)*	28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: XX **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end menner es stated. 2 **Medical Examfnar**: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date end place, and due to tha causa(s) and manner stated.

29b. Signature end title of certifier	29c. License number	29d. Date signed *(Month, Day, Year)*
▶	D41901	MAY 22, 1998

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

ZIAD MIRZA M.D., 3007 E. NORTHERN PARKWAY, BALTIMORE, MARYLAND, 21214

State Registrar

31. Date filed *(Month, Day, Year)*	32. Registrar's Signeture
MAY 27 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha lew requiras that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RD

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16418

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth BARROW
2. Date of Death (Month, Day, Year): May 23 98
3. Time of Death: 8.45 PM
4a. Facility Name (If not institution, give street and number): Mariner Health of Mount Clare
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: CITY

Funeral Director

5. Social Security Number: 217-34-7205
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 108 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 15, 1889
9. Birthplace (State or Foreign Country): SOUTH CAROLINA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 1217 W. FAYETTE STREET
10f. Zip Code: 21223
10g. Citizen of What Country? USA.

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): HENRY DRENNON
18. Mother's Name (First, Middle, Maiden Surname): SARAH (UNKNOWN)

19a. Informant's Name/Reletionship (Type, Print): JANIE B. ISSAC (GREAT NIECE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2125 W. FAYETTE STREET, BALTO, MD. 21223

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WESTERN STAR CEME.
Date: 5-28-98
20c. Location - City or Town, State: CATONSVILLE, MD.

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrest
Due to (or as a consequence of):
b. Myocardial Infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Ali I. Baykaler, M.D.
29c. License number: D02031
29d. Date signed (Month, Day, Year): May 27-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALI I. BAYKALER, M.D 831 Poplar Grove St. Baltimore, MD 21216

State Registrar

31. Dete filed (Month, Day, Year): MAY 27 1998
32. Registrar's Signature: ▶ Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16419

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN BASSLER
2. Date of Death: Month MAY Day 25 Year 1998
3. Time of Death: 1:15AM
4a. Facility Name (If not institution, give street and number): St. Agnes Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 404-12-3415
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 7, 1921
9. Birthplace (State or Foreign Country): W. Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 103 Laurel Ave.
10f. Zip Code: 21061
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner
16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): John Novak
18. Mother's Name (First, Middle, Maiden Surname): Helen Matusak

19a. Informant's Name/Relationship (Type, Print): Mary Kondilidis / Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 Coach Lane Baltimore, MD 21225

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Mem. Park
Date: May 29, 1998
20c. Location - City or Town, State: Parkville, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Kirkley-Ruddick Funeral Home, 421 Crain Hwy. S.E. Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MULTIPLE MYELOMA — 24 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: BBonaparte M.D
29c. License number: P11016
29d. Date signed (Month, Day, Year): MAY 25 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BERNADETTE BONAPARTE ST AGNES HOSPITAL, BALTIMORE MD 21229

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

NAME HELEN BASSLER

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16420

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mildred C. BAKer

2. Date of Death Month: 5 Day: 23 Year: 98

3. Time of Death: 5 A.M

4a. Facility Name *(If not institution, give street and number)*: J. H. Bayview Med. Center

4b. City, Town, or Location of Death: Balto. Md

4c. County of Death: N.A

Funeral Director

5. Social Security Number: 214 22 4963

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 10-7-17

9. Birthplace *(State or Foreign Country)*: Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: N. A.

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 800 Exeter HALL AVE

10f. Zip Code: 21218

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 grade; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse

16b. Kind of Business/Industry: South Balto Gen,

17. Father's Name *(First, Middle, Last)*: George Stanford

18. Mother's Name *(First, Middle, Maiden Surname)*: Blanche Thompson

19a. Informant's Name/Relationship *(Type, Print)*: Donald BAKer

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 800 Exeter Hall Ave Balto MD 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arbutus Mem PK

Date: 5/28/98

20c. Location - City or Town, State: Arbutus Md

21. Signature of Funeral Service Licensee: Joseph B. Locks Jr

22. Name and Address of Facility: Locks Funeral Home 1304 N. Central Ave

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Acute Cerebrovascular Disease days

Due to (or as a consequence of):

b. Hypertension years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Obstructive Hydrocephalus

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D08358

29d. Date signed *(Month, Day, Year)*: 5/26/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gracita K. Patricio 703 S. Clinton St Balt. MD 21224

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16421

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VERNELL BROWN
2. Date of Death: Month May Day 25 Year 1998
3. Time of Death: 10:00p.m.
4e. Facility Name (If not institution, give street and number): 409 Maple Lane
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218 18 8788
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months ____ Days ____
If Under 24 Hrs.: Hours ____ Min. ____
8. Date of Birth (Month, Day, Year): June 9,1915
9. Birthplace (State or Foreign Country): Va.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 409 Maple Lane
10f. Zip Code: 21222
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steel Worker
16b. Kind of Business/Industry: Bethlehem Steel

17. Father's Name (First, Middle, Last): Joseph Brown
18. Mother's Name (First, Middle, Maiden Surname): Jennette Sears

19a. Informant's Name/Relationship (Type, Print): Aileen Brown/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 409 Maple Lane Baltimore, Md. 21222

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hills Cemetery
Date: 5/29
20c. Location - City or Town, State: Balto. MD

21. Signature of Funeral Service Licensee: James A. Morton
22. Name and Address of Facility: James A. Morton & Sons F.H. 1701 Laurens St. Balto., Md. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. KIDNEY FAILURE — 3 years

Due to (or as a consequence of): b. ATHEROSCLEROTIC CARDIAC DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c. Hypertension

Due to (or as a consequence of): d. Diabetes mellitus

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Gastrointestinal bleeding

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kevin A Rossiter MD
29c. License number: MD D34859
29d. Date signed (Month, Day, Year): 5/26/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kevin A. Rossiter, MD Johns Hopkins Bayview Med Center 4940 Eastern Ave. Balt MD

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998
32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16422

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Bell
2. Date of Death (Month, Day, Year): May, 23, 1998
3. Time of Death: 8:30 pm
4a. Facility Name (If not institution, give street and number): Bon Secours Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 217-07-9331
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 5, 1912
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County:
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 722 Stamford Road
10f. Zip Code: 21229
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorcad
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 — College (1-4or 5+): 0
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Bus Driver
16b. Kind of Business/Industry: State Goverment

17. Father's Name (First, Middle, Last): James H. Bell
18. Mother's Neme (First, Middle, Meiden Surneme): Ruth P Snively

19a. Informant's Name/Relationship (Type, Print): Teresita C. Whitney / Per. Rep
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 718 Stamford Road, Baltimore, Maryland, Maryland 21229

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Placa of Disposition (Neme of cemetery, cremetory or other piece): Balt-Washington Crematory
Date: 5/25
20c. Location - City or Town, State: Laurel Maryland

21. Signature of Funeral Service Licansee: [signature]
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23e. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death): a. Pneumonia — 10 days
Due to (or as e consequenca of): Urosepsis
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet Initiated events resulting in deeth) Lest:
b. Due to (or es e consequenca of):
c. Due to (or as a consequenca of):
d.

Part II. **Other aignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive pulmonary disease
Coronary artery disease.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year):
28b. Time of Injury: M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify):
28f. Location (Street end Number or Rurel Route Number, City or Town, State):

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and plece, and due to the ceuse(s) end manner es stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and plece, end due to the cause(s) end manner stated.
29b. Signature end title of certifier: [signature], Medical House Officer
29c. License number: D45148
29d. Dete signed (Month, Dey, Year): May, 23, 1998
30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print): Ricardo Osorno, M.D. Bon Secours Hospital 2000 W. Baltimore Street, Baltimore, Maryland 21223

State Registrar

31. Date filed (Month, Dey, Year): MAY 27 1998
32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10 of 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16423

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SHARIFAH BEY
2. Date of Death: Month MAY Day 21 Year 1998
3. Time of Death: 1642
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL SYSTEMS
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 146-32-2249
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 58 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6-4-1939
9. Birthplace (State or Foreign Country): D.C.

Usual Residence of Decedent

10a. State: Md
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1301 Lakeside Avenue
10f. Zip Code: 21218
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade — College (1-4 or 5+): B.A. Degree
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Child Care Provider
16b. Kind of Business/Industry: Growing Mind Learning Center

17. Father's Name (First, Middle, Last): Willie T. Stephans
18. Mother's Name (First, Middle, Maiden Surname): Hilda Harris

19a. Informant's Name/Relationship (Type, Print): Rosalyn Rashiduddin - Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1715 Ingram Road Baltimore, Md 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest
Date: 527-98
20c. Location - City or Town, State: Owings Mills, Md 21215
21. Signature of Funeral Service Licensee: Gabrielle Cook
22. Name and Address of Facility: March F.H. West 4300 Wabash Avenue Balto, Md

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MULTIPLE SYSTEM ORGAN FAILURE — 2 weeks

Due to (or as a consequence of):
b. PERITONITIS — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. PERFORATED VISCUS

Due to (or as a consequence of):
d. GASTROSTOMY DEHISCENCE

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Eugene Chomo
29c. License number: D51173
29d. Date signed (Month, Day, Year): 5/22/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eugene Chomo 22 South Greene Street Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Physician/Medical Attending Physician: The law requires that the death certificate be executed within 24 hours of death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit.

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend: #8 Per Informant Film G760 61-98RC

Certificate of Death

Reg. No. 98 16424

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Bremer

2. Date of Death (Month, Day, Year): May 24 1998

3. Time of Death: 17:05 pm

4a. Facility Name (If not institution, give street and number): Mercy

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: 674

Funeral Director

5. Social Security Number: 216-03-4313

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): ~~May~~ JUNE 28, 1909

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2881 Chesterfield Avenue

10f. Zip Code: 21213

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary"(0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Medical Records Secretary

16b. Kind of Business/Industry: Mercy Hospital

17. Father's Name (First, Middle, Last): Henry Bremer

18. Mother's Name (First, Middle, Maiden Surname): Mary Held

19a. Informant's Name/Reletionship (Type, Print): Mr. Bill Griggs / Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 905 Stormont Circle Baltimore, MD 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other piece): Most Holy Redeemer Cemetery

Date: 5/30/98

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Servica Licensee: ▶ Timothy S. Haw

22. Name end Address of Fecility: Leonard J. Ruck Funeral Home, Inc. 5305 Harford Road Baltimore, MD 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death)

a. Pseudomonal Sepsis — 7 days

Due to (or as a consequenca of):

b. Neutropenia

Due to (or as a consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. ovarian cancer

Due to (or es e consequence of):

d.

Part II. **Other signifIcant conditIons** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1☐ Yaa 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred et the time, date and pleca, and due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and pleca, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Karen A. Kozicki MD

29c. License number: D40744

29d. Date signed (Month, Day, Year): May 24, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): K.A. Kozicki Mercy Hospital 301 St. Paul Pl, Balto, MD 21202

31. Date filed (Month, Day, Year): MAY 27 1998

32. Registrar's Signature: Julia Davidson-Pindell

State Registrar

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16425

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Marie	Stella	Ballatt	May 26 1998	7:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
233 Eisenhower Court	Odenton	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
n/a	1☐ M 2☒ F	86 Yrs.			Oct. 19, 1911	Sierra Leone

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Odenton	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
233 Eisenhower Ct.	21113	Sierra Leone

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Teacher	Sierra Leone Public Schools

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Samuel Ballatt	Humu Deen

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Evelyn Findlay / Daughter	233 Eisenhower Ct., Odenton, MD 21113

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Green Mount Crematory	5/27/98	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Stephen D. Lohrmann	CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. MULTIPLE MYELOMA	~1 year
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. RESPIRATORY ARREST	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
☒ 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Isabella C. Martinez	D45014	May 26 / 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ISABELLA C. MARTINEZ 8379 CHERRY LANE LAUREL MD 20707

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 27 1998	Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16426

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SAMUEL LEROY BAKER
2. Date of Death: Month 05 Day 22 Year 1998
3. Time of Death: 11 a.m. 00
4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214 24 0795
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): FEB. 20, 1928
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 172 BRANDON RD
10f. Zip Code: 21212
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yas 2 [X] No Specify:
14. Race - Amarican Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PLANNING ADMINISTRATOR
16b. Kind of Business/Industry: MARYLAND STATE GOVERNMENT

17. Fathar's Nama (First, Middle, Last): EUGENE FISHPAUGH
18. Mother's Neme (First, Middle, Meiden Sumama): GRACE ELIZABETH BAKER

19a. Informent's Neme/Reletionship (Type, Print): LAURA F. BAKER / WIFE
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code): 172 BRANDON RD, BALTIMORE MD 21212

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from Stata 4 [ ] Donetion 5 [ ] Othar (Specify)
20b. Place of Disposition (Neme of cematary, cremetory or other piece): GREEN MOUNT CREMATORY
Date: 5/23/98
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Stephen D Lohrmann
22. Name and Address of Facility: CAFA STEPHEN D. LOHRMANN P.A. 8717 GREEN PASTURES DR., BALTIMORE MD 21286

Physician /Medical Examiner

23a. Part1. Enter tha disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failura. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Ceuse (Finel diseese or condition resulting in death): a. MYOCARDIAL INFARCTION
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last: b.
Due to (or es a consequenca of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.: ANOXIC BRAIN ENCEPHALOPATHY PNEUMONAE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of causa of death? 1 [ ] Yas 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Phyaician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Fadi Merhi, M.D.
29c. Licansa number: P 11401
29d. Data signed (Month, Day, Year): 05 22 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FADI EL MERHI 5601 LOCH RAVEN BLVD. BALTIMORE, MD. 21239

State Registrar

31. Date filed (Month, Dey, Year): MAY 27 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16427

Item 8 Per FH Film G759 5-27-98 rja

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Andrew Barrett, Jr.

2. Date of Death: Month May Day 21 Year 1998

3. Time of Death: 6:45 AM

4a. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 199-05-9089

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 14 ~~1997~~ 1917

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Cockeysville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 724 Warren Road

10f. Zip Code: 21030

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Heavy Equip. Mechanic

16b. Kind of Business/Industry: Trucking

17. Father's Name (First, Middle, Last): James A. Barrett, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Ruby Josephine L. Moore

19a. Informant's Name/Relationship (Type, Print): Ruth A. Barrett/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 724 Warren Road, Cockeysville, MD 21030

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Dulaney Valley Memorial Gardens | Date: 5/23/98

20c. Location - City or Town, State: Timonium, MD

21. Signature of Funeral Service Licensee: Bryan W. Clary

22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RENAL FAILURE ACUTE/CHRONIC

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. CORONARY HEART DISEASE

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D41141

29d. Date signed (Month, Day, Year): 5/21/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dominick Memoli, M.D. 9 Schilling Rd., Hunt Valley, MD 21030

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998

32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16428

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thelma Dorothy Cook

2. Date of Death: Month: May; Day: 22; Year: 1998

3. Time of Death: 7:20 A. M.

4a. Facility Name (If not institution, give street and number): 3507 Brendan Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-09-6149

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 8, 1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 3507 Brendan Avenue

10f. Zip Code: 21213

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9th Grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machine Operator

16b. Kind of Business/Industry: Spice Company

17. Father's Name (First, Middle, Last): Burnett Durham

18. Mother's Name (First, Middle, Maiden Surname): Anna Marie Fisher

19a. Informant's Name/Relationship (Type, Print): Edward L. Cook (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3507 Brendan Avenue, Baltimore, Maryland 21213

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Church

Date: 5/26/98

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee:

22. Name end Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Cerebellar degeneration — 4 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Dfd tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the ceuse(s) end menner stated.

29b. Signature and title of certifier:

29c. License number: D20673

29d. Dete signed (Month, Day, Year): 5/22/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Greg Lowe 7672 Belair Rd Baltimore, MD 21206

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16429

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGUERITE E. COSDEN

2. Date of Death Month / Day / Year: MAY 21, 1998

3. Time of Death: 430PM.

4a Facility Name *(If not institution, give street and number)*: FALLSTON GENERAL HOSPITAL

4b. City, Town, or Location of Death: FALLSTON

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 220-38-7868

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 56 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: DEC 24, 1941

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: HARFORD

10c. City, Town or Location: JOPPA

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1008 MARINER ROAD

10f. Zip Code: 21085

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: FRANK FARACE

18. Mother's Name *(First, Middle, Maiden Surname)*: NORMA E. LETMATE

19e. Informant's Name/Relationship *(Type, Print)*: ANDREW L. PHILLIPS (SON)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1008 MARINER ROAD - JOPPA, MD. 21085

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: NEW CATHEDERAL CEMETERY

Date: 5/26/98

20c. Location - City or Town, Stete: BALTIMORE

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death)

a. CANCER

Due to (or as a consequence of):

b. THROMBOCYTOPENIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

Due to (or as a consequenca of):

c. GASTROINTESTINAL BLEED

Due to (or as a consequence of):

d. PNEUMONIA

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requiras thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted. 2☐ **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: [signature] MD

29c. License number: D45921

29d. Date signed *(Month, Day, Year)*: MAY 22 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. SYED F. MAHMOOD - 200 MILTON AVENUE - FALLSTON, MD. 21047

State Registrar

31. Date filed *(Month, Dey, Yeer)*: MAY 27 1998

32. Registrar's Signature: [signature] Julia Davidson-Randall

15

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16430

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): REBECCA CLARK
2. Date of Deeth (Month, Dey, Yeer): MAY 24, 1998
3. Time of Death: 4:07 P.M.

4a. Facility Name (If not institution, give street and number): 17 N. CALHOUN STREET (HOME)
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 219-42-7005
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthdey): 50 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): DEC 19, 1947
9. Birthplece (State or Foreign Country): DANVILLE, VA.

Usuel Residence of Decedent

10a. State: MARYLAND
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 17 N. CALHOUN STREET.
10f. Zip Code: 21223
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: AFRO. AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): RECEPTIOIST
16b. Kind of Business/Industry: YWCA

17. Fether's Name (First, Middle, Last): LINWOOD REESE
18. Mother's Neme (First, Middle, Maiden Surname): VIRGINIA SPRATT REESE

19e. Informent's Name/Reletionship (Type, Print): ANNIE M. DINGLE DAUGHTER
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 3214 MCELDERRY STREET, BALTIMORE, MARYLAND

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other place): WESTERN STAR CEMETERY
Dete: 5/29/98
20c. Location - City or Town, State: CATONSVILLE, MD.

21. Signeture of Funerel Service Licensee: ▶ LLOYD M. ESTEP
22. Neme end Address of Facility: ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23e. Pert I. Enter the diseesa, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or hert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediete Ceusa (Finel disease or condition resulting in deeth): e. Breast Cancer — Approximete Intervel: 3years

Due to (or as a consequance of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceusa (Diseesa or Injury that initiated events resulting in death) Lest:

b. Due to (or as e consequance of):

c. Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: OVARIAN Cancer 2years

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year):
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred:
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, Stete):

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and place, end due to the ceuse(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and mennar stated.

29b. Signeture end Title of Certifier: ▶ Paul Celano, MD
29c. License number: D30929
29d. Date signed (Month, Day, Year): 5/27/98

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): PAUL CELANO, MD 6569 N. Charles St, BALTIMORE MD 21204

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 27 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 29c Per Field Rep. Film G759 5-27-98 rja

Certificate of Death

Reg. No. 98 16431

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Arthur	Carnes		may	22	1998	21:13

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St Agnes Hospital	Baltimore	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-09-0492	1☒ M 2☐ F	85 Yrs.					Dec. 23, 1912	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Dundalk	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7010 B Mornington Road	21222	United States

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, apecify Cuben, Mexican, Puerto Rican, etc.)	14. Reca - American Indien, Bleck, White, etc.
1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Yeer or Detes: WWII	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
11 Years		Steelworker	Steel Industry

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
Patrick Joseph Carnes	Frances M. Simpson

19a. Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Frances Parker Niece	1902 Willow Spring Road Baltimore, MD 21222

20a. Method of Disposition	20b. Plece of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, Stete
1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)	Sacred Ht. of Jesus Cem.	5/26/1998	Dundalk, Maryland

21. Signature of Funeral Service Licensee	22. Name end Address of Facility
Patrit M Hennesy	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

		Approximete Intervel Between Onset end Death
Immediate Ceuse (Final diseese or condition resulting in deeth) e.	Acute Myocardial Infarction	1week
Due to (or es a consequenca of):	Cecal Volvulus	1week
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events reaulting in deeth) Lest b.		
Due to (or es e consequence of):		
c.		
Due to (or es e consequenca of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Chronic Obstructive Pulmonary Disease

23b. **Did tobacco use contributa to the ceuse of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an eutopsy performed?	24b. Were autopsy findings eveilable prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes case referred to medical exeminer?	26. Plece of Deeth (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined			1☐ Yes 2☐ No	
	28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29e. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(a) end menner as steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
A Cervone MD	P08224 ~~2011~~	May 22, 1998

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

A. Cervone MD

State Registrar

31. Dete filed (Month, Day, Yeer)	32. Registrer's Signeture
MAY 27 1998	Julia Davidson-Randall

NAME Arthur Carnes

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16432

Amend: #5 Per FH Film G760 6-4-98RC

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
WILLIAM	DAVIS	May 22, 1998	12:45A

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	Baltimore	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
241-30-3525 ~~214 30 3525~~	1☒ M 2☐ F	77 Yrs.			12-03-20	NC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Randallstown	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizan of What Country?
3723 Offutt Road	21133	USA

11. Marital Status	12. Was Decadent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6th grade	NA	Food Distrubitor	Laborer

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ananias Davis	Unknown

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ellen Rivers + Diane Walker	3723 Offutt Road Randallstown, Maryland 21133

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, cramatory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)	Voshell Mem. Gardens	05-27-98	Dundalk, Md.

21. Signature of Funeral Service Licensee	22. Nama and Address of Facility
Bernard D Johnson	Baltimore, ,Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Causa (Final disease or condition resulting in death)	a. DIAPHRAGMATIC WEAKNESS	TEN YEARS
	Due to (or as e consaquanca of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. SPINAL RADICULOPATHY	TEN YEARS
	Due to (or as a consaquanca of):	
	c.	
	Due to (or as a consequenca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of causa of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examinar?	26. Place of Death (Chack only ona)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Mannar of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify)	28f. Location (Straat and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at the time, date and place, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at tha time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
MD.	RES. 000	MAY 22, 1998

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

KARI E. ROBERTS, MD TOWER 110, JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND 21205

State Registrar

31. Date filed (Month, Day, Year)	32. Registrars Signature
MAY 27 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16433

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGUERITE C. DAVISON
2. Date of Death: Month MAY Day 22 Year 98
3. Time of Death: 140 a.m.
4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-38-4879
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Dey, Yeer): 2/2/06
9. Birthpleca (State or Foreign Country): MARYLAND

Usuel Residenca of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: CARNEY
10d. Insida City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1914 HAVER HILL ROAD
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Raca - Amarican Indian, Black, Whita, etc. Specify: WHITE

15. Decedent's Education (Specify only highast grade completed): Elementery/Secondery (0-12): 4 YEARS; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER-VICE PRINCIPAL
16b. Kind of Business/Industry: TOWSON JR HIGH

17. Fethar's Neme (First, Middle, Last): HENRY WILLIAM SUCHTING
18. Mother's Name (First, Middle, Meiden Surneme): ANTOINNETTE LAMPE

19a. Informent's Neme/Reletionship (Type, Print): ROBERT L. SUCHTING NEPHEW
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 1578 PUTTY HILL AVE. TOWSON, MD 21286

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other pleca): PARKWOOD CEMETERY
Dete: 5/26/98
20c. Location - City or Town, Stata: BALTIMORE, MD

21. Signetura of Funeral Service Licensee: W. Johnson
22. Neme end Address of Facility: JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

		Approximete Interval Between Onset end Deeth
Immediate Ceuse (Finel diseese or condition resulting in death) a.	CEREBRO VASCULAR ACCIDENT	9 DAYS
Due to (or es a consequence of):		
Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in deeth) Lest b.		
Due to (or es a consequence of):		
c.		
Due to (or es e consequanca of):		
d.		

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.: PNEUMONIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end manner as stated. 2☐ **Medical Exeminer:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) end menner stated.

29b. Signetura and title of certifiar: W. Alajmeh M.D
29c. Licansa number: P 12126
29d. Date signed (Month, Day, Year): MAY 22 98

30. Neme and eddress of perse who completed cause of deeth (Item 23e) (Type, Print): WALID ABOUJAOUDE 6920 DONACHIE RD #705 BALTIMORE M.D 21239

State Registrar

31. Dete filed (Month, Day, Year): MAY 27 1998
32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16434

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Day

2. Data of Death — Month: May; Day: 22; Year: 1998

3. Time of Death: 6:15 PM

4a. Facility Name (If not institution, give street and number): Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-05-1145

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Nov. 29, 1909

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 711 Maiden Choice Lane

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chief Operator

16b. Kind of Business/Industry: C & P Telephone Co.

17. Father's Name (First, Middle, Last): George Phoebus

18. Mother's Name (First, Middle, Maiden Surname): Mamie Hickman

19a. Informant's Name/Relationship (Type, Print): Claire Fulton

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10540 Cross Fox Lane Columbia, Maryland 21044

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Washington Crem

Date: 5/23

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Stephen M Jenkins

22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure — weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D47447

29d. Date signed (Month, Day, Year): May 23, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Andrew Gazis Charlestown Medical Center Catonsville Md.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Name:

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16435

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELMER E. DeGRAW

2. Date of Death Month Day Year: MAY 21, 1998

3. Time of Death: 925/AM

4a. Facility Name *(If not institution, give street and number)*: LORREANN NURSING CENTER RIVERSIDE

4b. City, Town, or Location of Death: HARFORD CO.

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 213-07-0551

6. Sex: 1☐ M 2☐ F — X

7. Age *(In yrs. last birthday)*: 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 4-10-06

9. Birthplace *(State or Foreign Country)*: VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☐ Yes 2☐ No — X

10e. Street and Number: 3204 BRENDAN AVENUE

10f. Zip Code: 21213

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): +2 YEARS

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ELECTRICIAN

16b. Kind of Business/Industry: BETH. STEEL

17. Father's Name *(First, Middle, Last)*: HARRY DeGRAW

18. Mother's Name *(First, Middle, Maiden Surname)*: MARGARET UNKNOWN

19a. Informant's Name/Relationship *(Type, Print)*: MRS. LORRAINE GASIOR

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 404 ARROW WOOD CT. ABINGDON, MD. 21009

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ST. STANISLAUS CEM.

Date: 5-23

20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: Charles R. Kaczorowski

22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVE. BALTO. MD. 21222

Physician /Medical Examiner

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular disease — > 3 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: Lung cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: M28334

29d. Date signed *(Month, Day, Year)*: May 22, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LINDA FREIMUTH 161 E Wheel Road Bel Air MD 21015

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1998

32. Registrar's Signature: Julia Davidson-Randall

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

At Home: Elmer E. DeGraw

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16436

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Norleen A. Edwards
2. Date of Death: Month May, Day 25, Year 98
3. Time of Death: 1959
4a. Facility Name (If not institution, give street and number): Sinai Hospital ER-7
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 212-34-0268
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 59 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05-29-38
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: Md
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: ☒ 1 Yes 2 ☐ No
10e. Street and Number: 3303 Grenton Avenue
10f. Zip Code: 21214
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8th grade
College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cap inspector
16b. Kind of Business/Industry: Poly Seal Inc.

17. Father's Name (First, Middle, Last): Willie Felton
18. Mother's Name (First, Middle, Maiden Surname): Lillian Johnson

19a. Informant's Name/Relationship (Type, Print): Mamie Gregory
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17911 Bunker Hill Road Parkton, Maryland 21120

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery
Date: 05-29-98
20c. Location - City or Town, State: Md. Anne Arundel, Co.

21. Signature of Funeral Service Licensee: Valerie N. Davis
22. Name and Address of Facility: Baltimore, Maryland 21202
WM.C. March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Cardiovascular Disease 10yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Insulin Dependent Diabetes
Hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA Other: 4 ☐ Nursing Home 5 ☐ Residance 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Sulcide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: M. L. Frydenberg MD
29c. License number: D27315
29d. Date signed (Month, Day, Year): May 25, 1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. L. Frydenberg MD Sinai Hospital

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998
32. Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

98-2790-510
CMK
WILLIAM EDWARDS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16437

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM H. EDWARDS
2. Date of Death Month Day Year: MAY 17, 1998
3. Time of Death: 1609PM
4a. Facility Name (If not institution, give street and number): 3936 PENHURST AVENUE
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-70-7288
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 40 Yrs. | If Under 1 Yaar: Months / Days | If Undar 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): MARCH 29, 58
9. Birthplaca (State or Foreign Country): BALTIMORE, MD.

Usual Residenca of Decedent

10a. Stata: MARYLAND
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3936 PENHURST AVE.
10f. Zip Coda: 21215
10g. Citizen of What Country?: USA

11. Maritel Stetus: 1 [ ] Navar Marriad 2 [ ] Merriad 3 [ ] Widowed 4 [X] Divorced
12. Wes Dacedent Ever in U.S. Armed Forces? 1 [X] Yas 2 [ ] No If Yas, Give Yaar or Datas: 80-90
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1 [ ] Yas 2 [X] No Specify:
14. Race - Amarican Indien, Bleck, Whita, etc. Specify: AFRO. AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 12 | Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired): ARMY SERVICE
16b. Kind of Businass/Industry: U.S. ARMY

17. Father's Neme (First, Middla, Last): HAROLD H. EDWARDS SR.
18. Mothar's Nama (First, Middla, Maidan Surname): PEARL LEE

19a. Informent's Neme/Ralationship (Type, Print): PEARL LEE MOTHER
19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda): 3936 PENHURST AVE, BALTIMORE, MARYLAND 21215

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Place of Disposition (Nema of camatary, cramatory or othar place): CROWNSVILLE V.A. CEM. Data: 5/22/98
20c. Location - City or Town, Stata: CROWNSVILLE, MARYLAND

21. Signature of Funeral Service Licensee: LLOYD M. ESTEP — Lloyd M. Estep
22. Name and Address of Facility: ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that causad tha daath. Do not antar tha moda of dying, such es cardiac or respiratory arrast, shock, or heart failure. List only one cause on each lina. (Approximate Interval Between Onset and Deth)

Immediata Causa (Finai diseese or condition resulting in deeth)
a. Hanging
Due to (or as a consequence of):

Sequantialty list conditions, if any, taading to immadiate causa. Entar Undarlying Causa (Disaasa or Injury that Initiated evants rasulting in death) Last
b.
Dua to (or as a consequence of):
c.
Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the undarlying cause given in Part I.

23b. Did tobacco usa contribute to the cause of death? 1 [ ] Yas 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performad? 1 [ ] Yes 2 [X] No
24b. Wara autopsy findings availabla prior to complation of causa of death? 1 [ ] Yes 2 [ ] No

25. Was case referrad to medical examinar? 1 [X] Yas 2 [ ] No
26. Placa of Death (Check only ona): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Othar: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Othar (Specify)

27. Manner of Deeth: 1 [ ] Natural 2 [ ] Accidant 3 [X] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not be datarmined
28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify): Residence
28b. Time of Injury: 1557 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Subject Hanged self
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete): 3936 Penhurst Ave

29a. Cartifiar (Check only one): 1 [ ] **Certifying Physician:** To tha best of my knowledge, daath occurred at tha tima, data and placa, and dua to tha cause(s) and manner as stated. 2 [X] **Medical Examinar:** On the basis of examination and/or invastigation, in my opinion, deeth occurred at tha tima, data and place, and dua to tha causa(s) and manner stated.
29b. Signature and titla of cartifiar
29c. Licansa number: O.C.M.E.
29d. Date signed (Month, Day, Year): MAY 18, 1998
30. Nema and addrass of person who complated causa of daath (Item 23a) (Type, Print): David R Fowler — 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filad (Month, Day, Year): MAY 27 1998
32. Registrar's Signature

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed, filed by the funeral director, page 2 should be detached for use as the burial-transit

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16438

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Santa Josephine Fertetta

2. Date of Death (Month, Day, Year): May 23, 1998

3. Time of Death: 2:35 AM

4a. Facility Name (If not institution, give street and number): Genesis Eldercare - Hammonds Lane

4b. City, Town, or Location of Death: Brooklyn Park

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215-07-5181

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 3, 1911

9. Birthplace (State or Foreign Country): Louisiana

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Brooklyn Park

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 405 Waverly Avenue

10f. Zip Code: 21225

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Button Hole Maker

16b. Kind of Business/Industry: Tailoring Company

17. Father's Name (First, Middle, Last): Vincenzo Fertetta

18. Mother's Name (First, Middle, Maiden Surname): Francesca Calcagno

19a. Informant's Name/Relationship (Type, Print): Lori Fertetta (niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 405 Waverly Ave., Brooklyn Park, MD 21225

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetary, cramatory or other place): Dulaney Valley Mausoleum

Date: 5/26/98

20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: ▶ Brian A. Willen

22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediete Ceuse (Finel disease or condition resulting in death)

a. Meningioma — Approximate Interval: months

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Straet and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as steted. 2☐ **Medical Examiner**: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the ceuse(s) end manner stated.

29b. Signature and title of Certifier: ▶ M Delaney MD

29c. License number: D-40521

29d. Date signed (Month, Day, Year): May 27, 1998

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): DR. DELANEY 3350 Wilkens Avenue Suite 302 Baltimore, MD 21229

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998

32. Registrer's Signeture: ▶ Julia Davidson-Daniels

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16439

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Dey / Year	3. Time of Death
FRANCINE L. FLOREY	MAY 22, 1998	5:38AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2003 SHORT STREET	HALETHORPE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-46-8496	1☐ M 2☒ F	51 Yrs.			NOV. 18, 1946	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Halethorpe	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2003 Short Street	21227	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	1+	Assistant Director	Day Care

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Melvin Morton Durham	Frances Agnes O'Neal

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
James W. Florey - husband	2003 Short Street, Baltimore, Md. 21227

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Meadowridge Memorial Park	5/27/98	Elkridge, Md.

21. Signature of Funeral Service Licensee: Laura Dexter

22. Name and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge MP 7250 Washington Blvd., Elkridge, Md. 21075

Physician /Medical Examiner

23a. Part I. Enter the disease, injury, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or kidnt failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. METASTATIC CARCINOMA OF THE BREAST	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEEP VENOUS THROMBOSIS
PULMONARY EMBOLUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) and menner steted.

29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Kathleen Maerum	D36146	5-22-98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Kathleen Maerum, UNIV. OF MD Cancer Ctr, 22 South Greene St, 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 27 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

RKD

98-2854-510

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

WADE GRAY Items: 23 part I,27 per MEO G-761 7/1/98 rcb

Certificate of Death

Reg. No. 98 16440

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WADE GRAY
2. Data of Death Month: MAY Day: 23 Year: 1998
3. Time of Death: 10:05P.M.
4a. Facility Name (If not institution, give street and number): 300 E.MADISON STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214 78 9815
6. Sex: 1 X M 2 F
7. Age (In yrs. last birthday): 38 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN.14,1960
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 X Yes 2 No
10e. Street and Number: 4900 PALMER AVENUE
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S. OF A.

11. Marital Status: 1 X Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:
14. Raca - American Indian, Black, Whita, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12TH
Collaga (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): CONSTRUCTION WORKER
16b. Kind of Business/Industry: CONSTRUCTION

17. Fathar's Nama (First, Middle, Last): WILLIAM J. GRAY
18. Mothar's Name (First, Middla, Maiden Surnama): DELORES BAKER GRAY

19a. Informant's Name/Relationship (Type, Print): PAMELA GRAY (SISTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3723 DOLFIELD AVENUE BALTIMORE,MD.21215

20a. Mathod of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Nama of cametery, crematory or other pleca): MT. ZION CEMETERY
Data: 5/29/98
20c. Location - City or Town, State: BALTIMORE,MARYLAND

21. Signature of Funeral Service Licensee: LEWIS T. GWYNN Lewis T. Gwynn
22. Name and Address of Facility: LEWIS T. GWYNN FUNERAL HOME 21215 4517 PARK HEIGHTS AVE. BALTO.,MD.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequanca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 X Yes 2 No

24b. Ware autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 X Yes 2 No

26. Place of Death (Check only one)
Hospital: 1 Inpatiant 2 ER/Outpatiant 3 DOA
Other: 4 Nursing Home 5 Residence 6 X Other (Specify) CELL

27. Manner of Death: X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investagation 6 Could not be determined

28a. Date of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifiar (Check only one): 1 **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Donald G. Wright MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): MAY 24,1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16441

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Henry Lawrence Giza
2. Date of Death: Month May, Day 26, Year 1998
3. Time of Death: 00:51
4e. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-09-1665
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 7-9-11
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: A.A. CO.
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 932 POINT PLEASANT ROAD
10f. Zip Code: 21060
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 YEARS; College (1-4or 5+):
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BARBER
16b. Kind of Business/Industry: SELF EMPLOYED

17. Father's Name (First, Middle, Last): LAWRENCE GIZA
18. Mother's Name (First, Middle, Maiden Surname): AGNES SITO

19e. Informant's Name/Relationship (Type, Print): MS. HENRIETTA GIZA
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 932 POINT PLEASANT RD. GLEN BURNIE, MD. 21060

20e. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. STANISLAUS CEMETERY
Date: 5-29
20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: Charles R. Kaczorowski
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME, 2525 FLEET ST. BALTO. MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Adult Respiratory Distress Syndrome	3days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Pneumonia	4days
Due to (or as a consequence of):		
	c. Urinary obstruction	2weeks
Due to (or as a consequence of):		
	d. Prostate Cancer	5years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dilated Cardiomyopathy with Mitral Valve prolapse

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Furman McDonald, M.D.
29c. License number: RES-000
29d. Date signed (Month, Day, Year): May 26, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Furman McDonald, MD, Tower 11O, Johns Hopkins Hospital, Baltimore, MD

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 8058

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

98 16442

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NEHEMIAH, M. HOGG		2. DATE OF DEATH: MONTH MAY DAY 15 YEAR 1998	3. TIME OF DEATH: 2 p. M
4. SOCIAL SECURITY NUMBER: 232-28-9399	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 79 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year): November 9, 1918
8. BIRTHPLACE (State or Foreign Country): KENTUCKY			
9a. FACILITY NAME (If not institution, give street and number): Future Care at Canton Harbor	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE	9c. COUNTY OF DEATH: CITY	
RESIDENCE OF DECEDENT			
10a. STATE: MD	10b. COUNTY: CITY	10c. CITY, TOWN OR LOCATION: BALTIMORE CITY	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1300 ANGLESEA STREET APT. 1E	10f. ZIP CODE: 21224	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SUPERVISOR	16b. KIND OF BUSINESS/INDUSTRY: PLANT MILL
17. FATHER'S NAME (First, Middle, Last): BURNETT HOGG		18. MOTHER'S NAME (First, Middle, Maiden Surname): BERTHA SHEPERD	
19a. INFORMANT'S NAME (Type/Print): LINDA HAYES		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 57 STRAWHAT ROAD 2B OWINGS MILLS, MD 21117	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): GREEN MOUNT CEMETERY DATE 5/19	20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Elizabeth Selinski		22. NAME AND ADDRESS OF FACILITY: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE. BALTIMORE, MD 21224	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	e. Arteriosclerotic coronary artery disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Marion Kowalewska MD	D21022	▶ 5-18-98

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARION KOWALEWSKA MD 8604 HARFORD rd 21234

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
MAY 27 1998	Julia Davidson-Randall

OHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16443

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Melissa Holmes

2. Date of Death — Month: MAY Day: 22 Year: 1998

3. Time of Death: 1:00 PM

4a. Facility Name (If not institution, give street and number): Genesis Elder Care

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-32-9825

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 3, 1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3608 Keene Avenue

10f. Zip Code: 21214

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use ratired): Homemaker

16b. Kind of Busiess/Industry: Own Home

17. Fathar's Name (First, Middle, Last): Theodore W. Dize

18. Mother's Name (First, Middle, Maiden Surname): Margaret V. Evans

19a. Informant's Name/Relationship (Typa, Print): Charles F. Holmes Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 3608 Keene Avenue, Baltimore, Maryland 21214

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Cemetery

Date: 5/26/98

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Robert Modalz

22. Name and Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

Physician /Medical Examiner

23a. Part I. Enter tha disease, or complications that caused the death. Do not enter the moda of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one cause on aach line.

		Approximate Interval Between Onset and Death
Immediata Ceuse (Final disease or condition resulting in deeth) a.	CONGESTIVE HEART FAILURE	3 WEEKS
Dua to (or as a consequanca of): b.	RENAL FAILURE	5 WEEKS
Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	INSULIN DEPENDENT DIABETES MELLITUS	5 YEARS
Due to (or as a consequance of): d.		

Part II. **Othar significant conditions** contributing to death but not resulting in the underlying ceuse givan in Part I.

23b. Did tobacco uas contribute to the causa of death? 1☐ Yas 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to complation of ceuse of daath? 1☐ Yas 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☑ No

26. Placa of Daath (Check only ona)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Daath: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding Investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Spacify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29e. Certifier (Check only one): 1☑ **Certifying Phyaician:** To the best of my knowledge, deeth occurred at the tima, data and placa, and dua to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Margarita Vergara Soares

29c. License number: D16619

29d. Date signed (Month, Day, Year): May 22, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C. VERGARA – SOARES 100 N. BROADWAY ST. BALT. MD. 21231

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RB

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16444

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Blanche Elaine Hafer

2. Date of Death Month / Day / Year: May 22 1998

3. Time of Death: 6:15 pm

4a. Facility Name *(If not institution, give street and number)*: Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford Co.

Funeral Director

5. Social Security Number: 217-05-8164

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: November 11, 1916

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford Co.

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 204 Wakefield Drive

10f. Zip Code: 21014

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 th | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: William E. Fuller

18. Mother's Name *(First, Middle, Maiden Surname)*: Josephine Svehla

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Richard H. Hafer (Son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 204 Wakefield Drive Bel Air, Maryland 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Loudon Park Cemetery

Date: 5/26/98

20c. Location - City or Town, State: Catonsville, Md.

21. Signature of Funeral Service Licensee: ▶ Brian A. Wellen

22. Name and Address of Facility: Schimunek Funeral Home of Bel Air, 610 W. MacPhail Rd. Bel Air, Md. 21014 Inc.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction — 3 weeks

Due to (or as a consequence of):

b. Congestive Heart Failure — 3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Cardiomyopathy/Ischemic H. Disease — 3 years

Due to (or as a consequence of):

d. Chronic Renal Failure — 3 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Peptic Ulcer Disease

Pernicious Anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Perfecto V. Valarao MD

29c. License number: D16389

29d. Date signed *(Month, Day, Year)*: May 26, 1998

30. Name and address of person who completed cause of death (Item 23a) *(Type, Print)*: DR. PERFECTO VALARAO 1716 HARFORD ROAD ROOM 106 FALLSTON MD 21014

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16445

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RICHARD JOSEPH HOBACK SR.
2. Date of Death (Month, Day, Year): MAY 21 1998
3. Time of Death: 17:50
4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-88-9160
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 33 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 6, 1965
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Jarrettsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1907 Belleguard Drive
10f. Zip Code: 21084
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th grade | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plumber
16b. Kind of Business/Industry: Plumbing Company

17. Father's Name (First, Middle, Last): Jack Hoback
18. Mother's Name (First, Middle, Maiden Surname): Nancy Matassa

19a. Informant's Name/Relationship (Type, Print): Doris Hoback (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1907 Belleguard Drive, Jarrettsville, MD. 21084

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Memorial Gardens | Date: 5/26/98
20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: ▶ Brian C. Wellen
22. Name and Address of Facility: Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. HIGH-GRADE OSTEOSARCOMA	TWO YEARS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Diplisic Gordana, MD
29c. License number: RE5001
29d. Date signed (Month, Day, Year): MAY 21 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DIPLISIC GORDANA 600 N Wolfe St Baltimore, MD 21287

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998
32. Registrar's Signature: ▶ Julia Davidson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit.

98-2928-005
B.K.S

MOSE HENRY

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16446

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mose Gibson Henry
2. Date of Death (Month, Day, Year): MAY 22, 1998
3. Time of Death: 1350 PM
4a. Facility Name (If not institution, give street and number): 2925 VERMONT AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-09-9497
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 1,1915
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore Highlands
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2925 Vermont Avenue
10f. Zip Code: 21227
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [XX] Yes 2 [ ] No If Yes, Give Year or Dates: 13 APR 45 - 18 OCT 46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 7th. Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Meat Cutter
16b. Kind of Business/Industry: Packing Co.

17. Father's Name (First, Middle, Last): John N. Henry
18. Mother's Name (First, Middle, Maiden Surname): Mollie Henry

19a. Informant's Name/Relationship (Type, Print): John G. Henry / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 Cunning Ct. Baltimore MD 21220

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Louden Park Cemetery
Date: 5/26/98
20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: Billy M. Hyde
22. Name and Address of Facility: Hubbard Funeral Home,Inc. 4107 Wilkens Ave Baltimore MD 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CANCER OF PROSTATE AND CANCER OF THROAT

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [XX] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? INSPECTION 1 [ ] Yes 2 [XX] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [XX] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [XX] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [XX] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [XX] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Donald G Wright
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): MAY 22, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Donald G. Wright M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Medical Examiner/Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16447

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kathryn E. Henderson

2. Date of Death: Month MAY Day 24 Year 1998

3. Time of Death: 12 45 AM

4a. Facility Name (If not Institution, give street and number): Golden Oaks Nursing Home

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 082-14-7904

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): Dec. 24, 1906

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 15013 Laurel Oaks Lane

10f. Zip Code: 20707

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House wife

16b. Kind of Business/Industry: Own home

17. Father's Name (First, Middle, Last): John Little

18. Mother's Name (First, Middle, Maiden Surname): Carolyn Little Welch

19a. Informant's Name/Relationship (Type, Print): Elizabeth Ricklin/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15013 Laurel Oaks Lane Laurel, Maryland 20707

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Washington Crem. Date: 5/25

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceusad the death. Do not enter tha mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onsat and Death

Immediate Cause (Finel disease or condition resulting in death) a. Pneumonia — 1 MONTH

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceusa. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Andrew Kundrat M.D.

29c. Licensa number: D36716

29d. Date signed (Month, Day, Year): MAY 24, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Andrew Kundrat, M.D. 8317 Sherry Lane, Laurel, Md. 20707

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998

32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This certificate requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16448

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY HELEN HADERMAN
2. Date of Death: Month MAY Dey 22 Yesr 1998
3. Time of Death: 2:45 A.M.
4e. Fscility Neme (If not institution, give street and number): 3505 LOSRAC COURT
4b. City, Town, or Location of Deeth: PARKVILLE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 179-16-0087
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9/21/22
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usuel Residence of Decedent

10e. Stete: MD
10b. County: BALTIMORE
10c. City, Town or Location: PARKVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 3505 LOSRAC COURT
10f. Zip Code: 21234
10g. Citizen of Whst Country?: USA
11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- It Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indien, Bleck, White, etc. Specify: WHITE
15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondary (0-12): 12th GRADE; College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): SECRETARY
16b. Kind of Business/Industry: OFFICE
17. Fether's Neme (First, Middle, Last): THOMAS W. MURRAY
18. Mother's Neme (First, Middle, Maiden Surname): MARY M. SULLIVAN
19e. Interment's Neme/Reletionship (Type, Print): THOMAS HADERMAN SON
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2200 F WHITCOMB CIRCLE BALTIMORE, MD 21234
20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY, INC.
Dete: 5/26/98
20c. Location - City or Town, Stete: CATONSVILLE, MD
21. Signature of Funeral Service Licensee:
22. Neme end Address of Fecility: JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	e. BREAST CANCER.	3 years.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☑ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Phyaicisn**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier:
29c. License number: D38048
29d. Dete signed (Month, Day, Year): 5/22/98.

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): HOWARD GOLDMAN 7636 Belair Rd, 21236

State Registrar

31. Dete filed (Month, Day, Year): MAY 27 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Attending Physician: The law requires that the death certificate be executed within 72 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

5

98-2971-003
DDG
TODD J. HARTING

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16449

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Todd J. Harting
2. Dete of Deeth — Month / Dey / Year: MAY 25, 1998
3. Time of Death: 0330 AM
4e. Facility Neme *(If not institution, give street and number)*: 70 JOHNSON ROAD
4b. City, Town, or Location of Deeth: RIVERA BEACH
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 217-56-3779
6. Sex: 1 X M 2 ☐ F
7. Age *(In yrs. last birthdey)*: 31 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: June 23,1966
9. Birthplece *(Stete or Foreign Country)*: Maryland

Usual Residence of Decedent

10e. Stete: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Rivera Beach
10d. Inside City Limits: XX 1 Yes 2 ☐ No
10e. Street end Number: 70 Johnson Road
10f. Zip Code: 21122
10g. Citizen of Whet Country?: USA
11. Meritel Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No — If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 X No *Specify:*
14. Rece - American Indien, Bleck, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver
16b. Kind of Business/Industry: Transportation
17. Father's Neme *(First, Middle, Last)*: Charles O. Harting
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Sue H. Dunlap
19e. Informent's Neme/Reletionship *(Type, Print)*: Sue H. Harting
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 70 Johnson Rd. Rivera Beach, Md.21122
20e. Method of Disposition: 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Loudon Park Cemetery — Dete: 5/28/98
20c. Location - City or Town, Stete: Baltimore,Md.
21. Signeture of Funerel Service Licensee: Diane L Phillips
22. Neme end Address of Feciliti: Loudon Park FuneralHome 3620 WilkensAve Baltimore,Md.21229

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line. — Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. Gunshot Wound of Abdomen
Due to (or es e consequence of):
Sequentially list conditions, if eny, leeding to Immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest:
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24e. Wes en autopsy periormed? 1 X Yes 2 ☐ No
24b. Were autopsy findings aveileble prior to completion of cause of deeth? XX Yes 2 ☐ No

25. Wes case referred to medicel exeminer? 1 XX Yes 2 ☐ No
26. Piece of Deeth *(Check only one)*: Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 XX Residence 6 ☐ Other *(Specify)*
27. Menner of Deeth: 1 ☐ Neturel 2 ☐ Accident 3 X Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined
28e. Dete of Injury *(Month, Dey, Yeer)*: 5/25/98
28b. Time of Injury: 0200 M
28c. Injury et Work? 1 ☐ Yes 2 X No
28d. Describe how injury occurred: Subject Shot self
28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*: AT HOME
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*: 70 Johnson St. 21122

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2 XX **Medical Examiner**: On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted.
29b. Signeture and title of certifier: Jason Locke MD
29c. License number: O.C.M.E.
29d. Dete signed *(Month, Dey, Yeer)*: MAY 25, 1998
30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): J. JASON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: MAY 27 1998
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for usa as the burial-transit permit.

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16450

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): MABEL C. JEWS
2. Dete of Deeth: Month 5 Dey 23 Year 98
3. Time of Death: 5:15 PM
4a. Facility Name (If not institution, give street and number): Stella Maris Nursing Home
4b. City, Town, or Location of Deeth: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-12-2108
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Year): Feb. 07, 1913
9. Birthplece (Stete or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Pikesville
10d. Inside City Limits: 1☐ Yes 2☑ No
10e. Street and Number: 35- Evan Way
10f. Zip Code: 21208
10g. Citizen of Whet Country? USA

11. Mertel Stetus: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Rece - Americen Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Supervisor (OT)
16b. Kind of Busines/Industry: State Institution

17. Fether's Neme (First, Middle, Last): Stephen Cephas
18. Mother's Neme (First, Middle, Meiden Surneme): Annie Justice

19a. Informent's Neme/Reletionship (Type, Print): William Jews
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 35-Evan Way-Pikesville Maryland 21208

20a. Method of Disposition: 1☑ Buriel 2☐ Cremation 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Spacify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Waugh Cemetery
Dete: 5/28/98
20c. Location - City or Town, Stete: Cambridge, Maryland

21. Signeture of Funeral Service Licensee: Janelle C. Henry
22. Neme end Address of Facility: Henry Funeral Home P.A. 510 Washington St. Cambridge, MD. 21613

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. PNEUMONIA — days

Due to (or as a consequence of):
b. CVA — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Arteriosclerosis
Dementia.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: 15504
29d. Date signed (Month, Day, Year): 5-23-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] 2300 Tollway Valley Road Bel Air 21093

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998
32. Registrar's Signature:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16451

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BARBARA A. JOHNSON
2. Date of Death (Month, Day, Year): MAY 26 1998
3. Time of Death: 7:10AM
4e. Facility Name *(If not institution, give street and number)*: MANOR CARE-TOWSON
4b. City, Town, or Location of Death: N/A
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-14-7411
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 6, 1921
9. Birthplace *(State or Foreign Country)*: WEST VIRGINIA

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: TOWSON
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 509 EAST JOPPA RD.
10f. Zip Code: 21286
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12YRS; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE
16b. Kind of Business/Industry: HOMEMAKER

17. Father's Name *(First, Middle, Last)*: CHARLES McKENNA
18. Mother's Name *(First, Middle, Maiden Surname)*: MARY BROWN

19a. Informant's Name/Relationship *(Type, Print)*: CHARLES McKENNA JR(BROTH.)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 652 LOCUST AVE, WESTON, WEST VA. 26452.

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: DULANEY VALLEY MEM.
Date: 5/29/98
20c. Location - City or Town, State: TIMONIUM, MD.

21. Signature of Funeral Service Licensee: William R. Routt II
22. Name and Address of Facility: HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. metastatic breast cancer — 1 year
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*: N/A
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD.
29c. License number: D41104
29d. Date signed *(Month, Day, Year)*: 5.26.98
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): THEODORE C. HOUK M.D. 7825 YORK RD. TOWSON, MD. 21204.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item:6, per F.H. G-761 7/1/98 reb

Certificate of Death

Reg. No. 98 16452

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT SR. R. KEHRING
2. Date of Death (Month, Day, Year): MAY. 22, 1998
3. Time of Death: 1:30 PM.
4a. Facility Name (If not institution, give street and number): Church Hospital 100 N. Broadway
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-26-4763
6. Sex: XX M ~~F~~
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 28, 1930
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 704 S. Fagley Street
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1947-1951
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor
16b. Kind of Business/Industry: Social Security Administration

17. Father's Name (First, Middle, Last): John Kehring
18. Mother's Name (First, Middle, Maiden Surname): Anna Brundick

19a. Informant's Name/Relationship (Type, Print): Robert Kehring Jr. Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8032 Bank St. Balto. Md. 21224

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oaklawn Cemetery
Date: 5-26-98
20c. Location - City or Town, State: Balto. Md. 21224

21. Signature of Funeral Service Licensee: Rafael Jhonatt
22. Name and Address of Facility: Charles S. Zeiler & Son, Inc. 6224 Eastern Ave. Balto. Md. 21224

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. RENAL FAILURE — MONTHS

Due to (or as a consequence of):
b. NEPHROPATHY — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. DIABETES MELLITUS — YEARS

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CORONARY ARTERY DISEASE.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A.F. Nazemi MD
29c. License number: D17322
29d. Date signed (Month, Day, Year): MAY. 22, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): A.F. NAZEMI, M.D. CHURCH HOSPITAL BALT. MD 21231

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998
32. Registrar's Signature: Julia Davidson-Pendarvis

DHMH 16 Rev 6/95

98 16453

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

Nicholas Kogler

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Nicholas Kogler			2. DATE OF DEATH (Month, Day, Year): MAY 23 1998	3. TIME OF DEATH: 8:42 AM
4. SOCIAL SECURITY NUMBER: N/A	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.: 4	7. DATE OF BIRTH (Month, Day, Year): 05/23/98	8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER	9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON	9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: BelAir	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1103 Milchling Drive		10f. ZIP CODE: 21015	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: N/A	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A — College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A	16b. KIND OF BUSINESS/INDUSTRY: N/A	
17. FATHER'S NAME (First, Middle, Last): Timothy Kogler		18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Daughtry	
19a. INFORMANT'S NAME (Type/Print): G.B.M.C. PATHOLOGY	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6701 NORTH CHARLES ST. TOWSON, MD. 21204		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): GREEN MOUNT CREMATORY — DATE: 5/27/98	20c. LOCATION — City or Town, State: BALTO., MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William R. Jenkins III	22. NAME AND ADDRESS OF FACILITY: HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Penetrating DUE TO (OR AS A CONSEQUENCE OF):	4 min.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert Brenner MD	29c. LICENSE NUMBER: D 14287	29d. DATE SIGNED (Month, Day, Year): ▶ 5/23/98
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 1702 Reisterstown Rd — Robert Brenner, M.D. Ste 235; Baltimore MD 21208		
31. DATE FILED (Month, Day, Year): MAY 27 1998	32. REGISTRAR'S SIGNATURE: Jacqueline Davidson-Randall	

DHMH-16 Rev 1/89

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16454

Christopher Kogler

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
Christopher	Kogler	MAY	23	1998	11:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
GREATER BALTIMORE MEDICAL CENTER	TOWSON	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
N/A	1☒M 2☐F	Yrs.			2	16	05/23/98	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Harford	BelAir	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1103 Milchling Drive	21015	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☐No If Yes, Give Year or Dates: N/A	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
N/A	N/A	N/A	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Timothy Kogler	Catherine Daughtry

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
G.B.M.C. PATHOLOGY	6701 NORTH CHARLES STREET TOWSON,MD. 21204

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	GREEN MOUNT CREMATORY	05/27/98	BALTO.,MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ William R. Jenkins III	HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO.,MD. 21212.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Prematurity	2hrs 16min
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Robert Brenner	D14287	05/23/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Robert Brenner, M.D.
1700 REISTERSTOWN RD STE 235 Baltimore MD 21208

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 27 1998	▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16455

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas Leonard Lober
2. Date of Death: Month May Day 23 Year 1998
3. Time of Death: 2:32 PM
4a. Facility Name (If not institution, give street and number): Fallston General Hospital
4b. City, Town, or Location of Death: Fallston
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 217-09-5000
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 13, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Fallston
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2300 Carlo Road
10f. Zip Code: 21047
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Details: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 9th grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman
16b. Kind of Business/Industry: Beverage Company

17. Father's Name (First, Middle, Last): George Lober
18. Mother's Name (First, Middle, Maiden Surname): Josephine Reiley

19a. Informant's Name/Relationship (Type, Print): Elizabeth Lober (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2300 Carlo Road, Fallston, MD 21047

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory
Date: 5/27/98
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Thomas J. Sodaro
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. CONGESTIVE HEART FAILURE	3 DAYS
Due to (or as a consequence of):	ASPIRATION PNEUMONIA	3 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: INSULIN DEPENDENT DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Andrew Nowakowski MD
29c. License number: D08096
29d. Date signed (Month, Day, Year): MAY 23, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANDREW NOWAKOWSKI MD 125 N. MAIN ST. BEL AIR, MD 21014

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998
32. Registrar's Signature: ▶ Julie Davidson-Randall

To Be Completed by Funeral Director

Thomas Lober
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out, give it to the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

1H

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State of Maryland / Department of Health and Mental Hygiene

98 16456

Certificate of Death

Reg. No.

LYON, THOMAS
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name *(First, Middle, Last)*: Thomas E. Lyon		2. Date of Death: Month MAY Day 24 Year 1998	3. Time of Death: 11:55 pm
4a. Facility Name *(If not institution, give street and number)*: GREATER BALTIMORE MEDICAL CENTER	4b. City, Town, or Location of Death: TOWSON	4c. County of Death: BALTIMORE	
5. Social Security Number: 172-09-3767	6. Sex: 1☒M 2☐F	7. Age *(In yrs. last birthday)*: 86 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)	8. Date of Birth *(Month, Day, Year)*: July 04, 1911
9. Birthplace *(State or Foreign Country)*: Annapolis, Md.			

Usual Residence of Decedent

10a. State: Maryland	10b. County: Baltimore Co.	10c. City, Town or Location: Towson	10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 1115 Concordia Drive	10f. Zip Code: 21286	10g. Citizen of What Country?: United States	

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*	14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4 or 5+): 03		16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Engineer	16b. Kind of Business/Industry: Martin-Marietta

17. Father's Name *(First, Middle, Last)*: Frank Lyon	18. Mother's Name *(First, Middle, Maiden Surname)*: Mabel Emery
19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Mabel (nee Gentry) Lyon (Wife)	19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1115 Concordia Drive Towson, Maryland 21286

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*	20b. Place of Disposition *(Name of cemetary, cramatory or other place)*: Hilltop Service Corp.	Date: 5/26/98	20c. Location - City or Town, State: Towson, Maryland
21. Signature of Funeral Service Licensee: Jeffrey L. Gair ▶ Jeffrey L. Gair	22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204		

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. RESPIRATORY FAILURE

Due to (or as a consequence of):
b. PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. ADENOCARCINOMA OF LUNG

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*		28f. Location *(Street and Number or Rural Route Number, City or Town, State)*	

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]	29c. License number: 044560	29d. Date signed *(Month, Day, Year)*: 5/25/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): NAME OR. JEFF ALEXANDER 10755 FALLS RD SUITE 460 LUTHERVILLE MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1998	32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

RKD
98-2931-003
JOHN
MARTIN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene — 98 16457

Items: 23 part I,27 per MEO G-760 6/15/98 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John E. Martin
2. Date of Death (Month, Day, Year): MAY 22, 1998
3. Time of Death: 6:16 A.M.
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 216-42-5240
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 53 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 9, 1944
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Linthicum
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 696 W. Maple Rd.
10f. Zip Code: 21090
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cargo Representative
16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): Robert L. Martin
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth D. Schneider

19a. Informant's Name/Relationship (Type, Print): Rosemary M. Trumpler/Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 696 W. Maple Road. Linthicum, MD 21090

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen HAven Mem. Pk. — May 26, 1998
20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Kirkley-Ruddick Funeral Home, 421 Crain Hwy. S.E. GLen Burnie, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE AND THROAT CANCER

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Theodore M. King MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): MAY 23, 1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. KING — 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16458

MCALEER, ETHEL

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ethel Mae McAleer
2. Date of Death (Month, Day, Year): MAY 25, 1998
3. Time of Death: 3:07PM
4e. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER
4b. City, Town, or Location of Death: ROSEDALE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-18-2058
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 27, 1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 943 Alricks Way
10f. Zip Code: 21205
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8th Grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Stock Clerk
16b. Kind of Business/Industry: Department Store

17. Father's Neme (First, Middle, Last): William Zimmerman
18. Mother's Name (First, Middle, Maiden Surname): Catherine Zimmerman

19a. Informant's Name/Relationship (Type, Print): Patricia Mae Maguire (Dghtr)
19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 933 Alricks Way, Baltimore, Maryland 21205

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn
Date: 5/28/98
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Robert Woodall
22. Name end Address of Feciility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha moda of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition rasulting in daath):
a. ACUTE MYOCARDIAL INFARCTION — 19 DAYS
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceusa. Entar Underlying Cause (Disaasa or Injury that Initiated avants resulting in daath) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.
DEPRESSION
CLOSTRIDIUM DIFFICILE COLITIS

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Wara autopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was cesa raferred to medical examinar? 1☐ Yes 2☒ No
26. Placa of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be detarmined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledga, death occurred at the time, date and place, and due to the ceuse(s) and mannar as stated. 2☐ **Medical Examinar**: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.
29b. Signeture end title of certifier: Sheeka Antonio MD
29c. License number: RD# 188870
29d. Date signed (Month, Day, Year): 5/25/98

30. Name and eddress of person who complated ceuse of death (Item 23a) (Type, Print): SHEEKA ANTONIO MD 9000 FRANKLIN SQUARE DR BALTO, MD 21237

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16459

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Irish Mills

2. Date of Death: Month May Day 22 Year 1998

3. Time of Death: 9:08 PM

4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-86-7017

6. Sex: 1☐ M 2☐ F X

7. Age (In yrs. last birthday): 28 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 1, 1969

9. Birthplace (State or Foreign Country): MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☐ Yes 2☐ No X

10e. Street and Number: 105 ASPINWOOD WAY APT. f

10f. Zip Code: 21237

10g. Citizen of What Country?: U.S.A.

11. Meritel Status: X 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No X If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No X Specify:

14. Race - American Indian, Black, White, etc. Specify: NEGRO

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 11TH

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): UNEMPLOYED

16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): WILLIAMS MILLS

18. Mother's Name (First, Middle, Maiden Surname): CHRISTINE FRAZIER

19a. Informant's Name/Relationship (Type, Print): CHERYL WILLIAMS/ AUNT

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3223 BEAUMONT ST. PRINCEGEORGE CO, MD. 20748

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): KING MEMORIAL PARK

Date: MAY 27, 1998

20c. Location - City or Town, State: BALTO. CO., Md

21. Signature of Funeral Service Licensee: Calvin B. Scruggs, Jr.

22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO, MD. 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis — 1 day

Due to (or as a consequence of):

b. AIDS — 10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert McWilliams MD

29c. License number: RES-000

29d. Date signed (Month, Day, Year): May 22, 1998

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Robert McWilliams, Tower 110, 601 N. Wolfe St., Baltimore, MD 21287

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998

32. Registrar's Signature: Gina Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16460

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louis C. Mehring

2. Date of Death Month Day Year: May 25, 1998

3. Time of Death: 2:30 A.M.

4a. Facility Name (If not institution, give street and number): College Manor Assisted Living

4b. City, Town, or Location of Death: Lutherville

4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 215-03-4016

6. Sex: ☒ 1 M ☐ 2 F

7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Oct. 26, 1904

9. Birthpiece (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: ☒ 1 Yes ☐ 2 No

10e. Street and Number: 5318 Plainfield Avenue

10f. Zip Code: 21206

10g. Citizen of What Country?: U.S.A.

11. Marital Status: ☐ 1 Never Married ☐ 2 Married ☒ 3 Widowed ☐ 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? ☐ 1 Yes ☒ 2 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): ☐ 1 Yes ☒ 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th Grade | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chauffeur

16b. Kind of Business/Industry: Electronics

17. Father's Name (First, Middle, Last): Michael Mehring

18. Mother's Name (First, Middle, Maiden Surname): Frances Amhreim

19a. Informant's Name/Relationship (Type, Print): Carole Mehring/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5318 Plainfield Avenue, Baltimore, Maryland 21206

20a. Method of Disposition: ☒ 1 Burial ☐ 2 Cremation ☐ 3 Removal from State ☐ 4 Donation ☐ 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Redeemer Cemetery | Date: 5/28/98

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic coronary artery disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease

Demented

23b. Did tobacco use contribute to the cause of death? ☐ 1 Yes ☐ 2 No ☐ 3 Probably ☐ 4 Unknown

24a. Was an autopsy performed? ☐ 1 Yes ☐ 2 No

24b. Were autopsy findings available prior to completion of cause of death? ☐ 1 Yes ☐ 2 No

25. Was case referred to medical examiner? ☐ 1 Yes ☐ 2 No

26. Place of Death (Check only one): Hospital: ☐ 1 Inpatient ☐ 2 ER/Outpatient ☐ 3 DOA | Other: ☐ 4 Nursing Home ☐ 5 Residence ☐ 8 Other (Specify)

27. Manner of Death: ☐ 1 Natural ☐ 2 Accident ☐ 3 Suicide ☐ 4 Homicide ☐ 5 Pending Investigation ☐ 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? ☐ 1 Yes ☐ 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): ☐ 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D 21022

29d. Date signed (Month, Day, Year): 5-26-98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): M. Kawalousky 8604 Hanford Rd. 21234

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16461

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES MARKLEY
2. Date of Death Month: MAY Day: 22 Year: 1998
3. Time of Death: 2:20PM
4a. Facility Name *(If not institution, give street and number)*: JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 578-56-3346
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 58 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 21, 1940
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George
10c. City, Town or Location: Laurel
10d. Inside City Limits: [X] Yes 2 [ ] No
10e. Street and Number: 1107 Montrose Avenue
10f. Zip Code: 20707
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yas, Give Yaer or Dates:
13. Was Dacedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - Amarican Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12 College (1-4or 5+): Ø
16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: Federal Meat Inspector
16b. Kind of Business/Industry: US Government

17. Father's Neme *(First, Middle, Last)*: Herbert Markley
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Nellie Hostettler

19a. Informent's Neme/Reletionship *(Type, Print)*: Blanche L. Markley/Wife
19b. Melling Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 1107 Montrose Avenue, Laurel, Maryland 20707

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [X] Removal from State 4 [ ] Donetion 5 [ ] Othar *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Hillcrest Memorial Park
Dete: 5/30
20c. Location - City or Town, State: Pickens, S.C.

21. Signature of Funerel Servica Licensee: [signature]
22. Neme end Address of Facility: Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert failure. List only ona causa on aech line.

		Approximata Intervel Between Onset and Death
Immediete Cause (Finel disease or condition resulting in death) e.	PULMONARY FAILURE AND SEPTIC SHOCK	7 DAYS
Due to (or as e consequence of):		
Sequentially list conditions, if eny, leeding to immediete causa. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Last b.	ALLOGENEIC BONE MARROW TRANSPLANTATION	44 DAYS
Due to (or es e consequence of):		
c.	MULTIPLE MYELOMA	8 MONTHS
Due to (or es a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

(1) FIBROPROLIFERATIVE ACUTE RESPIRATORY DISTRESS SYNDROME (A·R·D·S)

(2) MULTI-ORGAN FAILURE

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were eutopsy findings aveilable prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Netural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) and menner stated.

29b. Signature and title of certifier: Ruemu E Birhiray MD
29c. License number: D47953
29d. Date signed *(Month, Day, Year)*: MAY 22 1998

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): RUEMU E. BIRHIRAY, MD, JOHNS HOPKINS ONCOLOGY CENTER, BALTIMORE

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1998
32. Registrer's Signeture: Julia Davidson-Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

12+1

98-2922-510
CMK
GLORIA NELSON

Amend: #5 Per FH Film G760 6-1-98RC

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16462

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Gloria	Ann	Nelson	May	21,	98	21:55pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1606 Little Jones Court	Baltimore	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-54-3875 ~~Unknown~~	1☐ M 2☐ F XX	56 Yrs.					08-21-41	Md

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1606 Little Jones Court	21237	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th Grade	NA	Homemaker	Laborer

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Horace Price	Lola Woods

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21237
Slyvester Vines	1606 Little Jones Court Baltimore, Maryland

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
☒ 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Kings Mem. Pk. Cem.	05-27-98	Randallstown, Md.

21. Signature of Funeral Service Licensee: Vanessa Cox

22. Name and Address of Facility: baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Hypertensive Arteriosclerotic Cardiovascular Disease

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

INSPECTION

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J. Laron Locke M.D.	O.C.M.E.	MAY 27, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar Signature
MAY 27 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16463

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY S. PLEASANT
2. Date of Death Month / Day / Year: MAY 25 1998
3. Time of Death: 3:05 AM
4a. Facility Name *(If not institution, give street and number)*: HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 240-16-8156
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: OCT 11, 1911
9. Birthplace *(State or Foreign Country)*: NORTH CAROLINA

Usual Residence of Decedent

10a. State: MD
10b. County: HOWARD
10c. City, Town or Location: HANOVER
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6471 LOUDON AVENUE
10f. Zip Code: 21076
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11TH GRADE | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: ACCOUNTING OFFICE
16b. Kind of Business/Industry: MONTGOMERY WARDS

17. Father's Name *(First, Middle, Last)*: JESSIE A. STEVENS
18. Mother's Name *(First, Middle, Meiden Surname)*: PEARL DILLARD

19a. Informant's Name/Relationship *(Type, Print)*: MARY LEE WITOMSKI (DAUGHTER)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6471 LOUDON AVENUE - HANOVER, MD. 21076

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, crematory or other placa)*: LOUDON PARK CEMETERY
Data: 5/29/98
20c. Location - City or Town, State: BALTIMORE, MD21229

21. Signature of Funeral Service Licensee: Teresa L Klug
22. Name and Address of Facility: HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229

Physician /Medical Examiner

23a. Part I. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	GASIROINTESTINAL BLEEDING SECONDARY	1 WEEK.
Due to (or as a consequence of):	TO DIVERTICULOSIS.	
Sequentially list conditions, If any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in daath) Last b.		
Due to (or as a consequenca of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: LUNG CANCER, URINARY TRACT TUMOR, PARKINSONS DISEASE, CORONARY ARTERY DISEASE, MULTIPLE CEREBROVASCULAR ACCIDENTS.

23b. Did tobacco uaa contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Daath *(Check only one)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA | Othar: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be detarmined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the causa(s) and menner stated.

29b. Signature end title of certifier: J. Chawla (RESIDENT)
29c. License number: AS-2441614.
29d. Date signed *(Month, Day, Year)*: MAY, 25, 1998.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. JASVINDER CHAWLA, HARBOR HOSPITAL CENTER, BALTIMORE, MD.

State Registrar

31. Date filed *(Month, Day, Yaar)*: MAY 27 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 2 per FH Film G759 5-27-98 rja

Certificate of Death

Reg. No. 98 16464

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anthony Vincent Puleo

2. Data of Death: Month 24 May 25, Day, Year 1998

3. Time of Death: 7:45am

4a. Facility Name (If not institution, give street and number): 1420 W. Joppa Road

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 083-24-1043

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 66 Yrs.

If Under 1 Yaer: Months, Days

If Under 24 Hrs.: Hours, Min.

8. Data of Birth (Month, Day, Yaar): June 9, 1931

9. Birthplace (State or Foraign Country): New York

Usual Rasidenca of Dacedant

10a. Stata: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Insida City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1420 W. Joppa Road

10f. Zip Coda: 21204

10g. Citizen of Whet Country?: USA

11. Maritel Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yes, Giva Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Rece - American Indian, Bleck, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grada complated): Elemantary/Secondary (0-12): 12; Collage (1-4or 5+): n/a

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired): Physical Education Instructor

16b. Kind of Businass/Industry: Marine Engineering

17. Father's Nama (First, Middle, Last): Antonio Puleo

18. Mothar's Nama (First, Middla, Maidan Surname): Filomena Liotta

19a. Informent's Neme/Reletionship (Type, Print): Mary Puleo/Wife

19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Code): 1420 W. Joppa Road, Baltimore, Maryland 21204

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Placa of Disposition (Name of cemetary, crematory or othar place): Balto.-Wash. Crematory

Date: 5/26/98

20c. Location - City or Town, Stete: Laurel, Maryland

21. Signature of Funeral Service Licensee: Bryan W. Clary

22. Nama and Addrass of Facility: Lemmon Funeral Home, 10 W. Padonia Road, Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Intarval Batween Onset and Death

Immediata Causa (Final disaesa or condition resulting in death)

a. Hepatocellular Carcinoma — Months

Dua to (or as a consequanca of):

b. Chronic Hepatitis C — Years

Sequentially list conditions, if eny, laading to immadiata causa. Entar Underlying Cause (Disaasa or Injury that initieted events resulting in daath) Lest

Due to (or as a consequence of):

c.

Dua to (or as a consaquanca of):

d.

Part II. **Other etgnificant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

23b. Did tobecco use contribute to the cause of death? 1 [ ] Yee 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings available prior to completion of causa of daath? 1 [ ] Yas 2 [ ] No

25. Was casa rafarrad to medical exeminar? 1 [ ] Yas 2 [X] No

26. Placa of Daath (Check only one): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA; Othar: 4 [ ] Nursing Homa 5 [X] Rasidanca 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28e. Placa of Injury - At homa, ferm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and pleca, and dua to tha causa(s) and mannar es stated. 2 [ ] **Medical Examiner:** On tha basis of examinetion end/or invastigetion, in my opinion, deeth occurred at tha tima, data and placa, and dua to the cause(s) and mennar stated.

29b. Signatura and title of cartifier: D. William Schlott, MD

29c. Licansa number: D10499

29d. Data signed (Month, Day, Year): May 26, 1998

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print): D. William Schlott, MD 10755 Falls Road, suite 360, Lutherville, MD 21093

State Registrar

31. Data filed (Month, Day, Yaar): MAY 27 1998

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16465

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Esther I. Pierson
2. Date of Death Month / Day / Year: May 16 1998
3. Time of Death: 11.35 P.M.
4a. Facility Name (If not institution, give street and number): Heritage Nursing Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-44-0893
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 7, 1908
9. Birthplace (State or Foreign Country): Wisconsin

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6737 Pine Avenue
10f. Zip Code: 21222
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles Prell
18. Mother's Name (First, Middle, Maiden Surname): Marie Heilman

19a. Informant's Name/Relationship (Type, Print): Yvonne Shupe/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6737 Pine Ave Baltimore, MD 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens Of Faith Cemetery
Date: 5-19-98
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Michael J. Nesin
22. Name and Address of Facility: Bradley-Ashton-Dabrowski-Matthews Funeral Home, Inc. 2134 Willow Spring Road Baltimore, MD 21222

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE — 4 YRS

Due to (or as a consequence of):
b. HCVD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. HYPERTENSION.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
LEFT BREAST CARCINOMA
HYPOTHYROIDISM.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ K. Dharmasena, M.D.
29c. License number: D-17753
29d. Date signed (Month, Day, Year): 5-18-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K. S. DHARMASENA, M.D. 710 CHURCH ST. BALTIMORE, MD 21225

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

SSN 216566237

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16466

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DUANE RIDLEY

2. Date of Death: Month MAY Day 23rd Year 1998

3. Time of Death: 11:20 pm

4a. Facility Name (If not institution, give street and number): THE GOOD SAMARITAN HOSPITAL OF MARYLAND

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: NA

Funeral Director

5. Social Security Number: 216-56-6237

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 48 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 04-27-50

9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Md

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3150 Elmora Avenue

10f. Zip Code: 21213

10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): Computer Sch.

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Experience

16b. Kind of Business/Industry: Disabled

17. Father's Name (First, Middle, Last): Hubert Thomas

18. Mother's Name (First, Middle, Maiden Surneme): Elsie Mae Ridley

19a. Informent's Name/Reletionship (Type, Print): Randy Nicholson

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 5722 Denwood Avenue Baltimore, Maryland 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Placa of Disposition (Neme of cemetery, crematory or other piece): Mt. Calvary Cemetery

Date: 05-30-98

20c. Location - City or Town, Stete: Md. Anne Arundel Co.

21. Signeture of Funeral Service Licensee: Bernard D Johnson

22. Neme and Address of Facility: Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. SEPSIS — 4 weeks

Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other signficant conditions** contributing to death but not resulting in the underlying cause given in Part I.

GASTROINTESTINAL BLEED - ENDOCARDITIS

CHRONIC RENAL FAILURE

23b. Did tobacco uee contribute to the cauee of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residenca 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, and due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Maurice Bachawati, MD

29c. License number: P11399

29d. Date signed (Month, Day, Year): MAY 23rd 1998

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): MAURICE BACHAWATI, THE GOOD SAMARITAN HOSPITAL OF MARYLAND, 5601 LOCH RAVEN BLVD, BALTIMORE MD 21239

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

1

State Registrar

31. Dete filed (Month, Day, Year): MAY 27 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 26 per Physician G-759 5/27/98 reb

Certificate of Death

Reg. No. 98 16467

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Susan L. Rackl	May 23,1998	2:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2117 Maple Road	Edgemere	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-64-9110	1☐ M 2☒ F	44 Yrs.			Feb. 2,1954	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Dundalk	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1727 Stokesly Road	21222	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2 Years	Nursing	Oncology

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John D. Walker	Mildred E. Bateman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mildred E. Walker Mother	2117 Maple Road Edgemere, Maryland 21219

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Oak Lawn Cemetery	5/26/98	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Megan E. Ruck	Duda-Ruck Funeral Home of Dundalk, Inc 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. metastatic vaginal sarcoma	6months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☒ Other (Specify) Mother's Residence

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Mark D. Moers MD	DS2422	May 26 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark D. Moers MD
9101 Franklin Square Dr. Suite 205 Baltimore, MD 21237

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 27 1998	▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

John D. Walker

Mildred E. Bateman

Mildred E. Walker Mother 2027 Maple Road Edgemere, Maryland 21219

x
x

DKR Lawn Cemetery 5/26/98 Baltimore, MD

Duda-Ruck Funeral Home of Dundalk, Inc
7922 Wise Ave. Dundalk, Maryland 21222

Metastatic rectal cancer

6months

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16468

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THOMAS SCOTT

2. Date of Death Month: MAY Day: 24TH Year: 1998

3. Time of Death: 05:00 AM

4a. Facility Name (If not Institution, give street and number): NORTH WEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE.

Funeral Director

5. Social Security Number: 219-32-9625

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): 04-08-38

9. Birthplace (State or Foreign Country): Md

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Pikesville

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 4711 Parmelee Road

10f. Zip Code: 21208

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married XX 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☒ Yes 2☐ No If Yes, Giva Yeer or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bleck, White, atc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 12th Grade

College (1-4or 5+): 3yrs.

16a. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired): Defense Dept.

16b. Kind of Business/Industry: Ft. Georges G. Meade

17. Father's Neme (First, Middle, Last): George Scott

18. Mother's Nema (First, Middle, Meiden Surneme): Maude Harrison

19a. Interment's Neme/Reletionship (Type, Print): Juanita Scott

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 4711 Parmelee Road Baltimore, Md. 21208

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other piece): Woodlawn Cemetery

Dete: 05-29-98

20c. Location - City or Town, Steta: Woodlawn, Md

21. Signature of Funerel Service Licensee: Bernard D Johnson

22. Neme end Address of Facility: Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the death. Do not anter tha moda of dying, such as cardiec or respiretory arrest, shock, or heert teilure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediete Ceuse (Finel disease or condition resulting in deeth)

e. MULTIPLE MYELOMA. — UNKNOWN

Due to (or es a consequence of):

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Last

b.

Due to (or es e consequance of):

c.

Due to (or es e consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

ATRIAL FIBRILLATION.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yas 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, term, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete end piace, and due to the ceuse(s) and manner steted.

29b. Signeture end title of certifier: Hamish

29c. License number: D 42723.

29d. Data signed (Month, Day, Year): MAY 24TH 1998.

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): HYVERAHALLI M HARISH. 3745 FOXFORD STREAM ROAD BALTIMORE MD 21236.

State Registrar

31. Deta filed (Month, Day, Year): MAY 27 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16469

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Genevieve Irene Steele

2. Date of Death Month / Day / Year: May 24 1998

3. Time of Death: 4:35pm

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 219-22-1724

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 20, 1925

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 607 Delaware Ave.

10f. Zip Code: 21060

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Mack Shiflett

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary McCue

19a. Informant's Name/Relationship *(Type, Print)*: Rev. Ollis Steele/Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 607 Delaware Ave. Glen Burnie, MD 21060

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Glen HAven Mem. Pk. Date: May 27, 1998

20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: David L Ebaugh

22. Name and Address of Facility: Kirkley-Ruddick Funeral Home, 421 Crain Hwy. S.E. Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failura. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cardiopulmonary Arrest	5 minutes
Due to (or as e consequence of): b.	Hypoglycemia	24 hours
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Severe malnutrition	3 months
Due to (or as a consequence of): d.	Pancreatic cancer with Liver metastasis	6 months

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Liver dysfunction

Recent Pancreato duodenectomy

Anasarca

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to complation of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Sulcida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D32654

29d. Date signed *(Month, Day, Year)*: May 24, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John P. Serlemitsos 1509 Ritchie Highway, Arnold, MD 21012

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1998

32. Registrar's Signature: Julie Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16470

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ernest W. Schiren

2. Date of Death — Month: MAY Day: 21 Year: 1998

3. Time of Death: 7-05 pm

4a. Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNEARUNDEL

Funeral Director

5. Social Security Number: 215-10-9474

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Aug. 24, 1915

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore Highlands

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4212 Baltimore Ave.

10f. Zip Code: 21227

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Mechanic

16b. Kind of Business/Industry: Automotive

17. Father's Name *(First, Middle, Last)*: John Schiren

18. Mothar's Name *(First, Middle, Maiden Surname)*: Celestine Affayroux

19a. Informant's Name/Relationship *(Type, Print)*: R. Evelyn Schiren / Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4212 Baltimore St., Baltimore, Maryland 21227

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Glen Haven Mem. Pk.

Date: May 26, 1998

20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name end Address of Facility: Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or haart failura. List only ona causa on each line.

Approximate Interval Between Onset and Death

Immediata Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disaasa or Injury that initiated avants rasulting in death) Last

b. RECENT STROKE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: HYPERTENSION

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings evelleble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was cese rafarred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only ona)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Home 5☐ Residence 8☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, straet, factory, office building, etc. *(Specify)*

28f. Location *(Streat and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, daath occurred at the tima, data and place, and due to the ceuse(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier ▶ [signature]

29c. License number: D51664

29d. Date signed *(Month, Day, Year)*: MAY 21 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUDHIR KUMAR AGARWAL, M.D NORTH ARUNDEL HOSPITAL, 301 HOSPITAL DRIVE, GLEN BURNIE, MD 21061

State Registrar

31. Data filad *(Month, Day, Year)*: MAY 27 1998

32. Registrar's Signature ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

SCHIREN, ERNEST W

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16471

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elizabeth Smith

2. Date of Death Month May Day 23, Year 1998

3. Time of Death: 4:20 p.m.

4a. Facility Name *(If not institution, give street and number)*: Lorien Nursing Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 212-05-8769

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 14, 1910

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 820 N. Monroe St.

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Hat Maker

16b. Kind of Business/Industry: Accessories

17. Father's Name *(First, Middle, Last)*: unk.

18. Mother's Name *(First, Middle, Maiden Surname)*: Jennie Spriggs

19a. Informant's Name/Relationship *(Type, Print)*: Herman L. Jackson/son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 820 N. Monroe St. Balto., MD 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King Memorial Park

Date: 5/28

20c. Location - City or Town, State: Randallstown, MD

21. Signature of Funeral Service Licensee: James A. Morton

22. Name and Address of Facility: James A. Morton & Sons Funeral Home, 1701 Laurens St. Balto., MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC ASPIRATION — WEEKS

Due to (or as a consequence of):

b. CVA / DEMENTIA — YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. IDDM — YRS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: IDDM, ASCVD, ANEMIA, ANGIODYSPLASIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end piece, end dus to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or Investigetion, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: , MD.

29c. License number: D41291

29d. Date signed *(Month, Day, Year)*: 5/26/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 21 CROSSROADS DR. #330 OWINGS MILLS, MD. 21117

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

98 16472
Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ALICE SCOTT
2. Date of Death — Month: MAY Day: 25, Year: 1998
3. Time of Death: 11p.m.
4a. Facility Name *(If not institution, give street and number)*: MANOR CARE NURSING HOME
4b. City, Town, or Location of Death: BALTO. CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 072-20-3757
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: NOV. 10, 1918
9. Birthplace *(State or Foreign Country)*: N/A

Usual Residence of Decedent

10a. State: Md
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 931 E. 41st STREET
10f. Zip Code: 21218
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* NEGRO

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 4th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SELF EMPLOYED
16b. Kind of Business/Industry: RESTAURANT

17. Father's Name *(First, Middle, Last)*: WILLIAM SCOTT
18. Mother's Name *(First, Middle, Maiden Surname)*: MATILDA SHEPPARD

19a. Informant's Name/Relationship *(Type, Print)*: ADA TAYLOR / NIECE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 931 E. 41st STREET BALTO., Md 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: VOSHELL MEM. GARDEN
Date: MAY 30
20c. Location - City or Town, State: , 1998 BALTO. CITY

21. Signature of Funeral Service Licensee: Calvin B. Scruggs Jr.
22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO., Md 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular Disease — 5years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*
1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier
29c. License number: D15872
29d. Date signed *(Month, Day, Year)*: May 26 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Harold Byrd MD 25 Main St. Reisterstown MD 21136

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1998
32. Registrar's Signature:

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

WRC
98-2952-510
JAMES W.
SEDLER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16473

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES W. SEDLER
2. Date of Death (Month, Day, Year): MAY 23, 1998
3. Time of Death: 9:05 PM.
4a. Facility Name (If not institution, give street and number): ST. AGNES HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-26-8680
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB 12, 1930
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3300 BENSON AVENUE - APT-314
10f. Zip Code: 21227
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yas, Give Year or Datas: 1951 TO 1953
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - Amaricen Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd GRADE | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BOOKBINDER
16b. Kind of Business/Industry: PRINTING COMPANY
17. Father's Name (First, Middle, Last): ALBERT SEDLER
18. Mother's Name (First, Middle, Maiden Surnama): MINERVIA UNKNOWN
19a. Informant's Name/Relationship (Type, Print): MARGARITA SEDLER (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3300 BENSON AVENUE-APT-314-BALTIMORE, MD 21227
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): PARKWOOD CEMETERY
Date: 5/27/98
20c. Location - City or Town, State: BALTIMORE
21. Signature of Funeral Service Licensee: ▶ Sally M Hyde
22. Name and Address of Facility: HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease
Due to (or as a consaquanca of):
Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaasa or injury that initiated events resulting in daath) Last
b.
Dua to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? INSPECTION 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of ceusa of death? 1 [ ] Yas 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yas 2 [ ] No
26. Place of Death (Check only ona): Hospital: 1 [ ] Inpatiant 2 [X] ER/Outpatient 3 [ ] DOA | Othar: 4 [ ] Nursing Home 5 [ ] Residance 6 [ ] Othar (Specify)
27. Mannar of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signatura and title of certifier: ▶ Donald G. Wright MD
29c. Licanse number: O.C.M.E.
29d. Date signed (Month, Day, Year): MAY 24, 1998
30. Nama and addrass of parson who complated cause of death (Item 23a) (Type, Print): Donald G. Wright M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998
32. Registrar's Signature: ▶ Jacki Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

8x1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16474

Item 8 Per FH Film G759 5-27-98 rja

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Lamont Sparks

2. Date of Death Month Day Year: May 24, 1998

3. Time of Death: 10:00 p.m.

4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 212-24-8363

6. Sex: 1☐M 2☐F XX

7. Age (In yrs. last birthday): 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): ~~April~~ August 10, 1933

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decadant

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Burtonsville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 3024 Brownstone Court

10f. Zip Code: 20866

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Evar in U,S. Armed Forcas? 1☒Yes 2☐No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 1☐Yas 2☒No Specify:

14. Race - Amaricen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Superintendent

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): John Sparks

18. Mothar's Name (First, Middle, Maidan Surnama): O'Della Mundwiler

19a. Informant's Name/Relationship (Type, Print): Clara E. Sparks/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3024 Brownstone Court, Burtonsville, Maryland 20866

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Placa of Disposition (Nama of cemetary, crematory or other place): Clearville Union Ch. Cem.

Data: 5/28

20c. Location - City or Town, State: Clearville, PA

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)

a. Myocardial Infarction — Hours

Due to (or es e consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in daath) Last

b. Arteriosclerotic Cardiovascular Disease — years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only ona)

Hospitel: 1☐Inpatient 2☒ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residenca 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 8☐Could not be determined

28a. Date of Injury (Month, Day Year): N/A

28b. Time of injury: M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On tha basis of examination and/or investigation, In my opinion, deeth occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D01852

29d. Data signed (Month, Day, Year): MAY 25 1998

30. Neme and address of persen who completed cause of death (Item 23e) (Type, Print): PAUL A. DEVORE, MD 4203 Queensbury Rd Hyattsville MD 20781

10+1

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Item 20b Per FH Film G759 5-27-98 rja

ADH
98-2758-033
IGNACY SHARBEK Items:17,18,19a per F.H. G-760 6/5/98 reb

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16475

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ignacy Romuald John Skarbek
2. Date of Death (Month, Day, Year): MAY 15, 1998
3. Time of Death: 19:30 PM
4a. Facility Name (If not institution, give street and number): 16020 OLD MARLBORO PIKE
4b. City, Town, or Location of Death: UPPER MARLBORO
4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 143-32-2499
6. Sex: XX M 2☐ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar. 30,1923
9. Birthplace (State or Foreign Country): Poland

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George
10c. City, Town or Location: Seabrook
10d. Inside City Limits: 1☐ Yes 2☑ No
10e. Street and Number: 9910 Treetop Lane
10f. Zip Code: 20706
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): Electrical Engineer
16b. Kind of Business/Industry: Electronics

17. Father's Name (First, Middle, Last): WLADYSLAW ~~Wladsylaw~~ Skarbek
18. Mother's Name (First, Middle, Maiden Sumeme): Antonina ~~Jasinkitis~~ JASINKAJTIS

19a. Informant's Name/Relationship (Type, Print): ~~Eva~~ EWA M. Skarbek/Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 9910 Treetop Lane, Seabrook, Maryland 20706

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Baltimore Washington Cr.
Date: 5/24 ~~5/23~~
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Fleck
22. Name and Address of Facility: Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset end Death)

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as e consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? XX Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence XX Other (Specify) Road side

27. Menner of Death: 1☐ Natural 2☑ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of injury (Month, Dey Year): 5/15/98
28b. Time of Injury: 1200 p M
28c. Injury at Work? 1☑ Yes 2☐ No
28d. Describe how injury occurred: fell off of a tractor onto back hoe
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Farm
28f. Location (Street and Number or Rural Route Number, City or Town, State): 16020 Marlboro Pike PG Co, Md

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated. XX Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature end titie of certifier: Dennis J. Clark
29c. License number: OCME
29d. Date signed (Month, Dey, Year): MAY 16 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Clark 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year): MAY 27 1998
32. Registrar's Signature:

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16476

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Paul S Schley
2. Date of Death — Month: May; Day: 26; Year: 1998
3. Time of Death: 7:15 AM
4a. Facility Name (If not institution, give street and number): Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-32-5567
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 63 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 22, 1934
9. Birthplace (State or Foreign Country): Baltimore, Md.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5706 Benton Heights Ave.
10f. Zip Code: 21206
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1957 1959
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Inspector
16b. Kind of Business/Industry: American National Can Co.

17. Father's Name (First, Middle, Last): Arthur H. Schley
18. Mother's Name (First, Middle, Maiden Surname): Genevieve Wagner

19a. Informant's Name/Relationship (Type, Print): Nancy M. Schley (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5706 Benton Heights Ave. Baltimore, Md. 21206

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cemetery — Date: 5/29/98
20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Milton J. Knight Jr — Milton J. Knight Jr.
22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Metastatic lung Ca to the Brain	one month
Due to (or as a consequence of): b.	Lung Ca.	7 years
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	R M L / R L L pneumonia	3 days
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Fadi Deeb M.D
29c. License number: AT2438946
29d. Date signed (Month, Day, Year): May 26, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Fadi Deeb, M.D. 201 E. University Pkw. Baltimore, MD 21218

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16477

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARK HARRISON SEWARD
2. Date of Death (Month, Day, Year): MAY 25, 1998
3. Time of Death: 3:15 pm
4a. Facility Name (If not Institution, give street and number): St. Agnes Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 214-18-1886
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 14, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Linthicum
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 209 Regency Circle
10f. Zip Code: 21090
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1941-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): math teacher
16b. Kind of Business/Industry: high school

17. Father's Name (First, Middle, Last): Robert Wilmer Seward
18. Mother's Name (First, Middle, Maiden Surname): Edna Seymour

19a. Informant's Name/Relationship (Type, Print): Ida Seward - wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 209 Regency Circle Linthicum, Maryland 21090

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery
Date: 5/28/98
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Ann Y. Zink
22. Name and Address of Facility: Loudon Park Funeral Home 3620 Wilkens Avenue Baltimore, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ACUTE UPPER GASTROINTESTINAL Bleeding — MINUTES
Due to (or as a consequence of):
b. ACUTE AND CHRONIC RENAL FAILURE — MONTHS
Due to (or as a consequence of):
c. Nephrosclerosis
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
RENAL HYPOPERFUSION, NEW ONSET ATRIAL FIBRILLATION WITH RAPID VENTRICULAR RESPONSE
Myelodysplastic Syndrome WITH REFRACTORY ANEMIA

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 X No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ATTENDING
29c. License number: D16200
29d. Date signed (Month, Day, Year): MAY 25, 1998
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. N. M. MACHIRAN 720C MAIDEN CHOICE LA, CATONSVILLE, 21228

State Registrar

31. Date filed (Month, Day, Yaar): MAY 27 1998
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020 — Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16478

SLODZINSKI, CARL

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CARL S. SLODZINSKI

2. Date of Death Month / Day / Year: MAY 25 1998

3. Time of Death: 1:25 pm

4a. Facility Name *(If not institution, give street and number)*: GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-18-4397

6. Sex: X 1 M 2 F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 9-28-12

9. Birthplace *(State or Foreign Country)*: POLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 X Yes 2 No

10e. Street and Number: 2610 FOSTER AVENUE

10f. Zip Code: 21224

10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married 2 X Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 YEARS; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TAILOR/SHOE REPAIR

16b. Kind of Business/Industry: SELF EMPLOYED

17. Father's Name *(First, Middle, Last)*: VALENTINE SLODZINSKI

18. Mother's Name *(First, Middle, Maiden Surname)*: CATHERINE UNKNOWN

19a. Informant's Name/Relationship *(Type, Print)*: MRS. PAULINE SLODZINSKI

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2610 FOSTER AVENUE BALTO. MD. 21224

20a. Method of Disposition: 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GREEN MOUNT CEMETERY

Date: 5-28

20c. Location - City or Town, State: BALTO. CITY MD.

21. Signature of Funeral Service Licensee: Charles R. Kaczorowski

22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO. MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIO - RESPIRATORY ARREST

Due to (or as a consequence of):

b. MYOCARDIAL INFARCTION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

d. PERIPHERAL VASCULAR DISEASE

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death *(Check only one)*: Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other *(Specify)*

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John

29c. License number: D33353

29d. Date signed *(Month, Day, Year)*: 5-26-98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DANIEL JOHN MD GBMC

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1998

32. Registrar's Signature: Julie Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16479

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EMMA SANDERS
2. Date of Death Month: MAY Day: 21 Year: 1998
3. Time of Death: 12:15 PM
4a. Facility Name *(If not institution, give street and number)*: NS BAY VIEW
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-05-5452
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 7-13-10
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: DUNDALK
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6723 ROBERTS AVENUE
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 YEARS; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: JOHN HABERKAM
18. Mother's Name *(First, Middle, Maiden Surname)*: LIZABETH MACK

19a. Informant's Name/Relationship *(Type, Print)*: MR. WILLIAM J. SANDERS JR.
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6723 ROBERTS AVE. BALTO. MD. 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: OAK LAWN CEMETERY
Date: 5-23-98
20c. Location - City or Town, State: BALTO. MARYLAND

21. Signature of Funeral Service Licensee: Charles R. Kaczorowski
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVE. BALTO. MD. 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CEREBROVASCULAR ACCIDENT — MOS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Matthew McNabney MD
29c. License number: D45757
29d. Date signed *(Month, Day, Year)*: MAY 21, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MATTHEW MCNABNEY 4940 EASTERN AVE, BALT MD 21224

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SANDERS, EMMA

4

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16480

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Willie, Turner
2. Dete of Deeth: Month May, Dey 22, Yeer 1998
3. Time of Death: 8:30PM
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Deeth: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 230-32-4092
6. Sex: 1☑M 2☐F
7. Age (In yrs. last birthday): 70 Yrs. — If Under 1 Yaar: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): February 2, 1928
9. Birthplace (Stete or Foreign Country): Va.

To Be Completed by Funeral Director

Usuel Residence of Decedant

10a. Stete: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑Yes 2☐No
10e. Street and Number: 2065 East Belevedere Ave.
10f. Zip Code: 21239
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐Naver Married 2☑Married 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces?: 1☐Yas 2☑No If Yes, Give Yeer or Detas:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☑No Specify:
14. Race - Americen Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elamantary/Secondary (0-12): 11th grade; College (1-4or 5+): N/A
16a. Dacedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): Laborer
16b. Kind of Business/Industry: Bethlehem Steel

17. Fether's Neme (First, Middle, Last): Willie Ben Turner
18. Mother's Nama (First, Middle, Maiden Sumame): Lela Chance

19e. Informent's Name/Relationship (Type, Print): Ollie Turner / wife
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2065 E. Belvedere Ave Baltimore, Md 21239

20a. Method of Disposition: 1☑Buriel 2☐Cremetion 3☐Removal from Stata 4☐Donetion 5☐Othar (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Arbutus Memorial Park — Dete: 5-22-98
20c. Location - City or Town, Stete: Baltimore, Md

21. Signatura of Funeral Service Licensee: Gabrielle Cook
22. Nama and Address of Facility: William C. March F/H West 4300 Wabash Ave. Baltimore, Md 21215

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert1. Enter the diseese, or complications thet ceused the deeth. Do not enter the mode of dying, such es cardiec or raspiratory errest, shock, or heart failure. List only one ceuse on eech lina.

		Approximata Interval Between Onset and Death
Immediete Ceusa (Finel disease or condition resulting in deeth) e.	Asssystole	30min
Dua to (or as a consequance of):		
Sequentielly list conditions, if eny, leeding to immediate causa. Entar Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest b.	Cardiomyopathy	1year
Dua to (or es e consequence of):		
c.	Coronary Artery Disease	10years
Due to (or as a consequance of):		
d.		

Pert II. **Other significent conditione** contributing to death but not rasulting in tha underlying ceuse given in Part I.

Diabetes
Hypertension

23b. **Did tobacco use contributa to the ceuee of death?** 1☐Yas 2☒No 3☐Probably 4☐Unknown

24a. Wes en autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings aveileble prior to completion of ceuse of death? 1☐Yes 2☐No

25. Was case referred to medical exeminar? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatiant 2☒ER/Outpetient 3☐DOA; Other: 4☐Nursing Home 5☐Residance 8☐Othar (Specify)

27. Mannar of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicida 5☐Pending investigation 6☐Could not be datarmined

28a. Date of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how Injury occurred
28e. Piece of Injury - At homa, farm, street, factory, office building, etc. (Spacify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒**Certifying Phyeician:** To tha bast of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner as steted. 2☐**Medical Examiner:** On tha basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) and manner steted.

29b. Signeture end title of certifier: Edward A Seidel MD
29c. Licanse number: D24918
29d. Date signed (Month, Dey, Yeer): May 22, 1998

30. Name end eddress of person who completad cause of death (Item 23e) (Type, Print): Edward A. Seidel, MD 5601 Loch Raven Baltimore MD 21239

State Registrar

31. Date filed (Month, Dey, Yeer): MAY 27 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16481

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wilma Urban

2. Date of Death: Month May Day 22 Year 1998

3. Time of Death: 03:40

4a. Facility Name (If not institution, give street and number): Mariner Health Care of Laurel

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 079-30-9387

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 11, 1903

9. Birthplace (State or Foreign Country): Germany

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14200 Laurel Park Drive

10f. Zip Code: 20707

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elamantary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Franz J. Stein

18. Mother's Name (First, Middle, Maiden Surname): Franciska Hofmann

19a. Informant's Name/Relationship (Type, Print): Sandra Thomas / Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15611 Bounds Avenue Laurel, Maryland 20707

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or othar place): Baltimore Washington Crem.

Date: 5/25

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, Maryland 20707

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one causa on aach lina.

Approximate Interval Between Onset and Death

Immediete Cause (Final disaase or condition resulting in death): a. Cerebrovascular Accident — Days

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immadiate ceuse. Entar Underlying Cause (Disaese or Injury that Initiated avents resulting in daath) Last

b.

Dua to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings availaible prior to completion of cause of daath? 1☐ Yes 2☒ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To tha best of my knowledga, daath occurred at tha tima, date and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examinar**: On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifiar: Jenny Y Moy MD

29c. License number: D43260

29d. Data signed (Month, Day, Year): May 23, 1998

30. Name and eddress of person who compiated ceuse of death (Item 23a) (Typa, Print): Jenny Y Moy, MD 13952 Baltimore Avenue, Laurel, Maryland 20707

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by tha attending physician and completed by the funeral director, page 2 should be detached for usa as tha burial-transit permit.

4

4.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16482

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDWARD E. WILLIAMSON
2. Date of Death: Month MAY Day 25TH Year 1998
3. Time of Death: 6:15AM
4a. Facility Name (If not institution, give street and number): GOOD SAMARITION HOSPITAL 5601 LOCK RAVEN BLVD
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-18-8692
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APRIL 12, 1926
9. Birthplace (State or Foreign Country): BALTIMORE, MD.

Usual Residence of Decedent

10a. State: MARYLAND
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2214 N. DUKELAND STREET.
10f. Zip Code: 21216
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 45-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: AFRO. AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALESMAN
16b. Kind of Business/Industry: MILLERS LIQUORS CO.

17. Father's Name (First, Middle, Last): SIDNEY WILLIAMSON
18. Mother's Name (First, Middle, Maiden Surname): CARRIE WILLIAMSON

19a. Informant's Name/Relationship (Type, Print): CHARLENE D. WILLIAMSON DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2035 BRADDISH AVE, BALTIMORE, MARYLAND 21216-3125

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): GARRISON FOREST CEM.
Date: 5/29/98
20c. Location - City or Town, State: OWINGS MILL, MARYLAND

21. Signature of Funeral Service Licensee: ▶ LLOYD M. ESTEP
22. Name and Address of Facility: ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC COLON CARCINOMA — 1 YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MEDICAL DOCTOR
29c. License number: P09306
29d. Date signed (Month, Day, Year): MAY 25TH 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCIS KWABLE ATTO GRE GOOD SAMARITAN HOSPITAL OF MARYLAND INC

State Registrar

31. Date filed (Month, Day, Year): MAY 27 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

8

RKD

98-2829-510

GARY
WARD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I,27,28a-f per MEO G-760 6/3/98 reb

Certificate of Death

Reg. No. 98 16483

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
GARY R. WARD SR.	MAY 19, 1998	9:28A.M.

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
732 N.CARROLLTON AVE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214 58 7994	1# M 2☐ F	44 Yrs.			6/13/53	MD.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A	BALTIMORE	1# Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
732 N. CARROLLTON AVE.	21217	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4# Divorced	1# Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2# No Specify:	Specify AFRO AMERICAN

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elamentary/Secondary (0-12)	College (1-4or 5+)		
12	3	SUPPLY CLERK	PRIVATE CO.

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumeme)
ELI WARD JR.	RUTH WARD

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RUTH WARD MOTHER	3911 DOLFIELD AVE. BALTO. MD. 21215 (APT.C)

20a. Mathod of Disposition	20b. Placa of Disposition (Name of camatery, crematory or other place)	Date	20c. Location - City or Town, State
1# Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	GARRISON FOREST V.A.	5/26/98	OWINGS MILLS, MD.

21. Signeture of Funeral Service Licansee: ▶ Carl A Doty

22. Name and Address of Facility: ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heert failure. List only one cause on each line.

Approximata Interval Batween Onset and Death

Immediate Cause (Finel disease or condition resulting in death)	a. NARCOTIC AND COCAINE INTOXICATION	
	Due to (or as a consequanca of):	
Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disaasa or injury that initiated avents resulting in death) Last	b.	
	Dua to (or as a consaquanca of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Placa of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Rasidence 6☐ Other (Specify)

27. Mannar of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☒ Could not be determined	found 5/19/98	unknown M	1☐ Yes 2☒ No	Unknown

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
found at home	732 N. CARROLLTON AVE. Baltimore, Md.

29a. Certifier (Check only one): 1☐ **Certifying Phyalcian:** To the best of my knowledga, death occurred at the time, date and placa, and due to tha cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	O.C.M.E.	MAY 20,1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	Registrar's Signature
MAY 27 1998	[signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16484

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: THOMAS RAYMOND WINN
2. Date of Death — Month: MAY; Day: 25; Year: 1998
3. Time of Death: 3:00 A.M.
4a. Facility Name *(If not institution, give street and number)*: OAK CREST VILLAGE CARE CENTER
4b. City, Town, or Location of Death: PARKVILLE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-18-3520
6. Sex: 1 ☐ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 7/17/22
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: PARKVILLE
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 8830 WALTHER BLVD. APT. 216
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SHEET METAL LAYOUT MECHANIC
16b. Kind of Business/Industry: MARTIN MARIETTA

17. Father's Name *(First, Middle, Last)*: RICHARD WINN
18. Mother's Name *(First, Middle, Maiden Surname)*: LAURA STUMPF

19a. Informant's Name/Relationship *(Type, Print)*: ANTHONY GALLO
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1220 TENFIELD ROAD TOWSON, MD 21286

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ST. STAINISLAUS CEM. — Date: 5/28/98
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Heather N. Hays
22. Name and Address of Facility: JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Aspiration Pneumonia

Due to (or as a consequence of): Stroke

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia; Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*: NA
28b. Time of Injury: M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Brian Zable, MD
29c. License number: D51620
29d. Date signed *(Month, Day, Year)*: 5/26/98
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRIAN ZABLE, MD Oak Crest Med. Ctr., Parkville, MD 21234

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 27 1998
32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10+1

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16485

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Deeth Month	Dey	Year	3. Time of Death
ALFRED	JAMES	WALSH	MAY	25	1998	5:55 AM

4e. Facility Name (If not institution, give street end number)	4b. City, Town, or Location of Deeth	4c. County of Deeth
GREATER BALTIMORE MEDICAL CENTER	TOWSON	BALTIMORE

Funeral Director

5. Social Security Number	6. Sax	7. Age (In yrs. last birthdey)	If Under 1 Yaar Months	Deys	If Undar 24 Hrs. Hours	Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplece (Stete or Foreign Country)
034-24-2700	X 1 M 2 F	67 Yrs.					Feb. 26, 1931	MA

Usuel Residence ot Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Lutherville	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
29 Bramleigh Road	21093	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 X Yas 2 No If Yes, Give Year or Detas:	1 Yas 2 X No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
	4	Manager	Restaurant

17. Father's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surneme)
Michael Joseph Walsh	Catherine Durkin

19e. Interment's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Joanne Walsh/wife	29 Bramleigh Road Lutherville, MD 21093

20e. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other place)	Dete	20c. Location - City or Town, Stete
1 X Buriel 2 Cremation 3 Removal trom Stete 4 Donation 5 Other (Specify)	Dulaney Valley Mem. Gdns.	05/28/98	Timonium, Maryland

21. Signature of Funeral Service Licensee	22. Neme end Address of Facility
Stephen Coster	Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

Physician /Medical Examiner

23a. Part1. Enter the diseese, or compilcetions thet caused tha daath. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert teilure. List only one ceuse on eech line.

		Approximete Interval Between Onset end Death
Immedete Ceuse (Finel disease or condition resulting in deeth)	e. adenocarcinoma of unknown primary	2yrs
	Due to (or es e consequence of):	
Sequentially list conditions, if any, leeding to immedete cause. Enter Underlying Cause (Diseese or Injury thet initieted events rasulting in death) Lest	b.	
	Due to (or as a consequence of):	
	c.	
	Dua to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24e. Wes en autopsy performed?	24b. Were autopsy tindings avellable prior to completion ot cause of death?
1 Yes 2 No 3 Probably 4 X Unknown	1 Yes 2 X No	1 Yes 2 No

25. Wes case referred to medical examiner?	26. Piece of Death (Check only one)	
1 Yes 2 X No	Hospitel: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Deeth	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1 X Neturel 2 Accident 3 Suicide 4 Homicide 5 Pending Investigetion 6 Could not be determined		M	1 Yes 2 No	
	28e. Piece of tnjury - At home, term, street, fectory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 X **Certifying Phyaician:** To the best of my knowledge, death occurred et the time, dete and place, end due to the ceuse(s) end menner es stated.
2 **Medicat Examiner:** On tha basis ot examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end placa, and due to tha cause(s) end manner steted.

29b. Signature and title of certifier	29c. Licensa number	29d. Date signed (Month, Day, Year)
	D44804	5/25/98

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)
KARIN M. DODLE MD 8028 Ritchie Highway Pasadena MD 21122

State Registrar

31. Dete tiled (Month, Day, Year)	32. Registrar's Signature
MAY 27 1998	

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Alfred Walsh

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16486

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
JAMES B. WATRISS	MAY 25 1998	6:15PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MERIDIAN AT BRIGHTWOOD		BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
564-22-9006	1☒M 2☐F	76 Yrs.			06-02-1921	NEW YORK

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	GLYNDON	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2601 BUTLER RD.	21071	USA

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Detes: WWII	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12YRS		LIVESTOCK TRANSPORTATION	LIVESTOCK TRANSPORTATION

17. Fether's Name (First, Middle, Last)	18. Mothar's Name (First, Middle, Malden Surneme)
FREDERICK NEWELL WATRISS	HELEN W. BARNEY

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
MICHAEL B. WATRISS(SON)	2611 BUTLER RD. GLYNDON,MD. 21071.

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Data	20c. Location - City or Town, State
1☐Burial 2☒Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)	GREEN MOUNT CREMATORY	05/26/98	BALTO.,MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
William R. Lowe III	HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO.,MD. 21212.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one ceuse on eech line.

		Approximete Interval Between Onset end Death
Immediata Cause (Final disease or condition resulting in death)	a. Cardiopulmonary Arrest	10 min.
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that Initiated evants resulting in daath) Last	b. Normal Pressure Hydrocephalus	3 years
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequance of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.

Multi-infarct Dementia

Prior history of Prostate CA

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicida 5☐Panding invastigation 6☐Could not be datarmined		M	1☐Yes 2☐No	

28e. Piece of Injury - At home, farm, street, fectory, office building, atc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and manner es stated. 2☐**Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and dua to the cause(s) and menner stated.

29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
William D. McConnell	MD D42129	05/26/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM D. McCONNELL M.D. 500 WEST UNIVERSITY PARKWAY BALTO.,MD.

State Registrar

31. Date filed (Month, Day, Yaar)	32. Registrar's Signature
MAY 27 1998	Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

6+1

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16487

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY FRANCES ALLUM
2. Date of Death (Month, Day, Year): MAY 27 1998
3. Time of Death: 15:50 PM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-52-3404
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 41 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 20, 1956
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1360 Andre Street
10f. Zip Code: 21230
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Clerical

17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Mary Frances Hunt

19a. Informant's Name/Relationship (Type, Print): David J. Allum / Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1360 Andre Street, Baltimore, Maryland 21230

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory
Date: May 29, 1998
20c. Location - City or Town, State: Baltimore City

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.
22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore, MD 21230

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. STATUS EPILEPTICUS — 2 HOURS

Due to (or as a consequence of):
b. MULTIPLE SCLEROSIS — 5 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
c. PNEUMONIA — 3 DAYS

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier: RESIDENT
29c. License number: A-1 244 1618
29d. Date signed (Month, Day, Year): MAY 27. 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): SHARIF CHOWDHURY 3001 S HANOVER STREET, BALTIMORE, MD HARBOR HOSPITAL CENTER

State Registrar

31. Date filed (Month, Day, Year): MAY 28 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16488

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): WESLEY AUSTIN
2. Dete of Death — Month: May; Dey: 20; Yeer: 1998
3. Time of Death: 10 25 AM
4e. Facility Name (If not institution, give street end number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 234-56-8506
6. Sex: 1☑ M 2☐ F
7. Age (In yrs. last birthday): 62 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): 11-20-35
9. Birthplece (State or Foreign Country): W. VA

Usuel Residence of Decedent

10a. Stete: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 1829 W. MOSHER STREET
10f. Zip Code: 21217
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☑ No — If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No Specify:
14. Race - American Indien, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 TH GRADE; College (1-4or 5+): N/A
16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER
16b. Kind of Business/Industry: PRIVATE INDUSTRY

17. Father's Neme (First, Middle, Last): HENRY AUSTIN
18. Mother's Name (First, Middle, Meiden Surneme): GUSSIE SAUNDERS

19e. Informent's Neme/Reletionship (Type, Print): ALPHONSO LAWSON
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 3704 W. SARATOGA ST., BALTO. MD. 21229

20e. Method of Disposition: 1☐ Buriel 2☑ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Placa of Disposition (Neme of cemetery, cremetory or other piece): METRO CREMATORY
Dete: 5-22-98
20c. Location - City or Town, Stete: BALTO. MD

21. Signeture of Funerel Service Licensee: ▶ Vaughn C. Greene
22. Neme end Address of Facility: VAUGHN C. GREENE FUNERAL SER. 5151 BALTO. NATL PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Pert I: Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line. — Approximete Interval Between Onset end Deeth

Immediete Cause (Finel diseese or condition resulting in deeth): e. Sepsis
Due to (or es e consequence of):
Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest:
b. Renal Failure
Due to (or es e consequenca of):
c.
Due to (or es e consequenca of):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☑ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No
26. Plece of Deeth (Check only one): Hospitel: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, death occurred et the time, date end placa, and due to the cause(s) end manner stated.

29b. Signeture end title of certifier: ▶ Malecha Chaudary, M.D.
29c. License number: 09502 A
29d. Date signed (Month, Day, Yeer): May 20, 1998

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): Malecha Chaudary, M.D. c/o Maryland General Hospital

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 28 1998
32. Registrer's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Wesley Austin

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16489

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy Abelson

2. Date of Death — Month: May; Day: 25; Year: 1998

3. Time of Death: 5:20am

4a. Facility Name *(If not institution, give street and number)*: Cherrywood Nursing Home

4b. City, Town, or Location of Death: Reisterstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-01-2611

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 78 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 25, 1919

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Owings Mills

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 4-F Bitterroot Ct.

10f. Zip Code: 21117

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bieck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 11; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Louis Eisman

18. Mother's Name *(First, Middle, Meiden Surneme)*: Molly Sherman

19a. Informent's Neme/Reletionship *(Type, Print)*: Mr. Bernard Abelson (Husband)

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 4 F Bitterroot Ct. Owings Mills, MD 21117

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Liberty Park-Shaarei Zion — Date: 5/28/98

20c. Location - City or Town, State: Randallstown MD

21. Signature of Funeral Service Licensee: Clarence Levinson Jeffers

22. Name end Address of Facility: Sol Levinson & Bros., Inc. 8900 Reisterstown Road Baltimore, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immedlete Ceuse (Finel disease or condition resulting in deeth)
e. Metastatic ovarian carcinoma — 6 months
Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in deeth) Lest
b. Due to (or es a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Gastrointestinal bleeding

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings sveileble prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end pleca, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Harry W. Kaplan MD

29c. License number: D40371

29d. Dete signed *(Month, Day, Year)*: 5/25/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr Harry W. Kaplan, MD 20 Crossroads Drive Owings Mills, Maryland 21117

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 28 1998

32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit.

4

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16490

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY EMMA ADAMS

2. Date of Death Month / Day / Year: MAY 26 1998

3. Time of Death: 1:55AM

4a. Facility Name *(If not institution, give street and number)*: 1808 E. FEDERAL STREET

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-12-5800

6. Sex: 1☐ M 2☑ F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAY 25 1909

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 1808 E. FEDERAL STREET

10f. Zip Code: 21213

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE

16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: WILLIAM CORNISH

18. Mother's Name *(First, Middle, Maiden Surname)*: CLARA THOMAS

19a. Informant's Name/Relationship *(Type, Print)*: ERMA O. ADAMS DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1808 E. FEDERAL ST. BALTO. MD 21213

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ASBURY BROADNECK UM CEM. Date: 5/30/98

20c. Location - City or Town, State: ANNAPOLIS MD

21. Signature of Funeral Service Licensee: ▶ Gloria Adams Jones

Name and Address of Facility: MARSHALL W. JONES, JR. FUNERAL HOME PA 4101 Edmondson Ave, Balto. Md. 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Acute Myocardial Infarction — 1 hour

Due to (or as a consequence of):

b. Coronary Artery Disease — 2 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Arteriosclerosis — 5 yrs.

Due to (or as a consequence of):

d. Hypertension — 10 yrs.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Glaucoma, Arthritis,

Mitral Regurgitation, PMH

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Date of Injury *(Month, Day Year)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M.D.

29c. License number: H47494

29d. Date signed *(Month, Day, Year)*: 5/26/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Monique Langston MD 21 Crossroads Owings Mill Md.

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 28 1998

32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16491

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MILTON ALEXANDER JR.

2. Date of Death Month: MAY Day: 22 Year: 1998

3. Time of Death: 12:35pm

4a. Facility Name *(If not institution, give street and number)*: LIBERTY MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-64-5966

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 42 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 3-12-56

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2029 BENTALOU AVE.

10f. Zip Code: 21216

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+): -0-

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TRUCK DRIVER

16b. Kind of Business/Industry: TRANSPORTATION

17. Father's Name *(First, Middle, Last)*: MILTON ALEXANDER, SR.

18. Mother's Name *(First, Middle, Maiden Surname)*: WILLIE LEE GAMBLE

19a. Informant's Name/Relationship *(Type, Print)*: EDWINA L. ALEXANDER (WIFE)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2029 BENTALOU AVE.-BALTIMORE, MD 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: WOODLAWN CEMETERY

Date: 5/27/98

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Juanita Hector CFSP

22. Name and Address of Facility: ELIZABETH L. PHILLIPS 1721-27 N. MONROE ST.-BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. HEPATIC ENCEPHALOPATHY — 8hrs.

Due to (or as a consequence of):
b. LIVER FAILURE — Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. LIVER CIRRHOSIS — Unknown

Due to (or as a consequence of):
d. ALCOHOLISM — Unknown

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COAGULOPATHY

GASTROINTESTINAL BLEEDING

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D45925

29d. Date signed *(Month, Day, Year)*: MAY 22 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHUKWUEMEKA C. UFOMADU LIBERTY MEDICAL CENTER LIBERTY HEIGHTS AVE, BALTIMORE 21225

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 28 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be completed and permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/cremation permit.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16492

Bryant, Lafayette

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lafayette Marion Bryant
2. Date of Death Month / Day / Year: MAY 27, 1998
3. Time of Death: 7:35 PM
4a. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 248-18-4667
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 15, 1919
9. Birthplace *(State or Foreign Country)*: South Carolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Middle River
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 716 Wampler Road
10f. Zip Code: 21220
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machinist
16b. Kind of Business/Industry: Steel Mill
17. Father's Name *(First, Middle, Last)*: LaFayette M. Bryant
18. Mother's Name *(First, Middle, Maiden Surname)*: Rosa Godwin
19a. Informant's Name/Relationship *(Type, Print)*: Eleanora M. Bryant (WIFE)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 716 Wampler Road Baltimore , Md. 21220
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gardens Of Faith Cemetery
Date: 5/30/1998
20c. Location - City or Town, State: Baltimore Co., Md.
21. Signature of Funeral Service Licensee: John W. Bruzdzinski
22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. HEART FAILURE	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. REOPERATIVE CORONARY ARTERY	2 HOURS
	Due to (or as a consequence of): c. BYPASS SURGERY	2 HOURS
	Due to (or as a consequence of): d. ATHEROSCLEROTIC CORONARY ARTERY DISEASE	18 YEARS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D40372
29d. Date signed *(Month, Day, Year)*: 5/27/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN C. LASCHINGER, M.D., 7620 YORK ROAD, TOWSON, M.D. 21204

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 28 1998
32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1071

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16493

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Shirley R. Burger
2. Date of Death Month / Day / Year: May 26, 1998
3. Time of Death: 06:00
4a. Facility Name *(If not institution, give street and number)*: 1 Smeton Place
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-18-6128
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 5-3-1926
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1 Smeton Place
10f. Zip Code: 21204
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Medical Records Clerk
16b. Kind of Business/Industry: Md. General Hospital

17. Father's Name *(First, Middle, Last)*: John Joseph Rock
18. Mother's Name *(First, Middle, Maiden Surname)*: Stella Cathern Peters

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Thomas J. Burger (Son)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3227 Stone Eagle Court, Abingdon, Maryland 21009

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery — Date: 5-30-98
20c. Location - City or Town, State: Parkville, Maryland

21. Signature of Funeral Service Licensee: ▶ Wallace S. Brooks Jr
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. hypertension — Due to (or as a consequence of): — 10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*: N/A
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶
29c. License number: D41104
29d. Date signed *(Month, Day, Year)*: 5.27.98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Theodore Hoke MD 7825 York Rd Towson MD 21204.

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 28 1998
32. Registrar's Signature: ▶ Julia Davidson Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be signed by the attending physician and within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit.

5

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16494

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MILDRED BRYANT

2. Date of Death Month Day Year: MAY 19, 1998

3. Time of Death: 8:50 PM

4a. Facility Name *(If not institution, give street and number)*: CATONSVILLE COMMONS

4b. City, Town, or Location of Death: CATONSVILLE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-22-5105

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 12, 1907

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 16 Fusting Ave

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Negro

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Organist

16b. Kind of Business/Industry: Church

17. Father's Name *(First, Middle, Last)*: Charles H. Brown

18. Mother's Name *(First, Middle, Maiden Surname)*: Lydia M. Dixon Brown

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Reita K. Carroll (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8259 Vosges Rd. Balto. Md. 21244

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arbutus Mem. Pk

Date: 5/26/98

20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. BOWEL PERFORATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Shelley, MD

29c. License number: D38708

29d. Date signed *(Month, Day, Year)*: MAY 20, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): SHELLEY M. CABBELL, 4000 Old Court Rd, Baltimore, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 28 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

98-2956-510

ANDRE D. BROWN

ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I,27,28a-f per MEO G-761 7/24/98 rev

Certificate of Death

98 16495
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Andre Donnell Brown
2. Date of Death Month: MAY Day: 24 Year: 1998
3. Time of Death: 4:45 A
4a. Facility Name (If not institution, give street and number): DEATON NURSING HOME
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-74-5893
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 36 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 3, 1962
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 611 South Charles St.
10f. Zip Code: 21230
10g. Citizen of What Country? USA

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: Afro-American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unemployed
16b. Kind of Business/Industry: Never worked

17. Father's Name (First, Middle, Last): William Brown
18. Mother's Name (First, Middle, Maiden Surname): Margaret Cobbs

19a. Informant's Name/Relationship (Type, Print): Mrs. Margaret Jackson (mother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2503 Coles St. Richmond, Va. 23234

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woshell Mem. Gardens
Date: 5/30/98
20c. Location - City or Town, State: Dundalk, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDITIS

Due to (or as a consequence of):
b. QUADRIPLEGIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. MULTIPLE STAB WOUNDS

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 X Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 ☐ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 X Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year): 1989
28b. Time of Injury: unknown M
28c. Injury at Work? 1 ☐ Yes 2 X No
28d. Describe how injury occurred: Subject was stabbed
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Maryland House of Correction
28f. Location (Street and Number or Rural Route Number, City or Town, State): Jessup, Md.

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Donald G. Wright MD
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): MAY 24, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 28 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 16496

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy Cook

2. Date of Death Month Day Year: May 24th 1998

3. Time of Death: 4:08am

4a. Facility Name *(If not institution, give street and number)*: Liberty Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 212-26-7926

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 20, 1918

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2225 Braddish Avenue

10f. Zip Code: 21216

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Milton Howard

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Parham

19a. Informant's Name/Relationship *(Type, Print)*: Peggy Johnson/daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 438 Random Road, Baltimore, Maryland 21229

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Breast Cancer

Due to (or as a consequence of):

b. Overwhelming Sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Severe Thrombocytopenia

Due to (or as a consequence of):

d. Gastro intestinal Bleeding

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☒ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kenan Adorni Medical House

29c. License number: D38993

29d. Date signed *(Month, Day, Year)*: 05/24/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kenan Adorni 2600 Liberty Hghts Baltimore MD 21215

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 28 1998

32. Registrar's Signature: Sisha Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

98-2991-005
B.K.S

DAMIEN COTRELL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16497

Physician * /Medical Examiner

1. Decedent's Name (First, Middle, Last): Damien Paul Cottrell
2. Date of Death (Month, Day, Year): MAY 26, 1998
3. Time of Death: 0745 AM
4a. Facility Name (If not institution, give street and number): 6900 NORTH RIVER DRIVE - IN WOODS
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-19-7308
8. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 19 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 26, 1978
9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Middle River
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 6812 Columbia Road
10f. Zip Coda: 21220
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Dacedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: School

17. Father's Name (First, Middle, Last): Danny Paul Cottrell
18. Mother's Name (First, Middle, Maiden Surname): Brenda Parks

19a. Informant's Name/Relationship (Type, Print): Brenda Shumaker (MOTHER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6812 Columbia Road Middle River, Md. 21220

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Crematory Date: 5/29/1998
20c. Location - City or Town, State: Baltimore Md.

21. Signature of Funeral Service Licensee: John W. Burkowske
22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Hanging
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Homa 5☐Residenca 6☒Other (Specify) AT SCENE

27. Manner of Death: 1☐Natural 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year): 5-26-98
28b. Time of Injury: 0735 M
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: subject Hanged self
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Woods
28f. Location (Street and Number or Rural Route Number, City or Town, State): 6900 North River Drive

29a. Certifier (Check only one): 1☐Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. Licansa number: O.C.M.E
29d. Data signed (Month, Day, Year): MAY 26, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 28 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend: #1,24a.25,26,27 Per MD Film G759 5-28-98RC

Certificate of Death

Reg. No. 98 16498

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LAURA CALKINS — ~~Calkins, Laura~~
2. Date of Death Month Day Year: May 7, 1998
3. Time of Death: 10:35 AM
4a. Facility Name *(If not institution, give street and number)*: 1321 Bonsal Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 204-18-0217
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 22, 1925
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1321 Bonsal Street
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Someone Elses Home
17. Father's Name *(First, Middle, Last)*: Charles Hennessey
18. Mother's Name *(First, Middle, Maiden Surname)*: Emma Gottestien
19a. Informant's Name/Relationship *(Type, Print)*: Rose Lockwood/neice
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6721 Graceland Avenue, Baltimore, Maryland 21224
20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*
Date
20c. Location - City or Town, State
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. chronic obstructive pulmonary disease — 5 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: hypertension

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rodney Brooks, MD
29c. License number: 043636
29d. Date signed *(Month, Day, Year)*: May 11, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 2323 Orleans Street Baltimore, MD 21224

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 28 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16499

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Cletus Cooke

2. Data of Daath — Month: May; Day: 25; Year: 1998

3. Tima of Death: 3:30 pm

4a. Facility Nama *(If not institution, give straat and number)*: Johns Hopkins Bayview Hospital

4b. City, Town, or Location of Daath: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 256-30-5733

6. Sax: ☒ M ☐ F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Yaar — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Data of Birth *(Month, Day, Year)*: July 10, 1926

9. Birthplaca *(Stata or Foreign Country)*: Georgia

Usual Rasidance of Dacedant

10a. Stata: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1 ☐ Yas 2 ☒ No

10e. Street and Number: 7952 Charlesmont Road

10f. Zip Coda: 21222

10g. Citizan of What Country?: United States

11. Maritel Status: 1 ☐ Navar Marriad 2 ☒ Marriad 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1 ☒ Yas 2 ☐ No — If Yas, Giva Yaar or Datas: Korean

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1 ☐ Yas 2 ☒ No *Spacify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedant's Education *(Specify only highast grada complatad)*

Elamantary/Secondary (0-12): G.E.D.

College (1-4or 5+):

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa ratired)*: Steelworker

16b. Kind of Businass/Industry: Steel Industry

17. Fathar's Nama *(First, Middla, Last)*: William Arthur Cooke

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Effie Lowe

19a. Informant's Name/Ralationship *(Type, Print)*: Mrs. Emma L. Cooke/Wife

19b. Mailing Addrass *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 7952 Charlesmont Road Dundalk, Maryland 21222

20a. Mathod of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of camatary, cramatory or othar place)*: Meadowridge Mem. Gdns. — Data: 5/28/1998

20c. Location - City or Town, Stata: Elkridge, MD

21. Signatura of Funaral Sarvica Licansaa: ▶ Johnny L. Ritter

22. Nama and Addrass of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that caused tha daath. Do not antar tha moda of dying, such es cardiac or raspiratory arrast, shock, or heart failura. List only ona causa on aach lina.

Approximata Intarval Batween Onsat and Death

Immediata Causa (Final disaasa or condition resulting in daath)

a. cerebral vascular accident

Dua to (or as a consequance of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaase or Injury that initiated avants rasulting in daath) Last

b.

Dua to (or as a consaquance of):

c.

Dua to (or as a consaquance of):

d.

Part II. **Other aignificant conditions** contributing to death but not rasulting in tha undarlying ceusa givan in Part I.

23b. Did tobacco uee contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performad? 1 ☐ Yas 2 ☒ No

24b. Wara autopsy findings eveilebla prior to completion of cause of daath? 1 ☐ Yas 2 ☒ No

25. Was casa rafarrad to madical axaminar? 1 ☐ Yas 2 ☒ No

26. Placa of Daath *(Check only one)*: Hospital: 1 ☒ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA — Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar *(Specify)*

27. Manner of Daath: 1 ☒ Natural 2 ☐ Accidant 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Panding Invastigation 6 ☐ Could not be datarminad

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At home, farm, straat, factory, offica building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1 ☒ **Certifying Physician:** To tha bast of my knowladga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. 2 ☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and tita of cartifiar: ▶ J Todd Baldanza MD

29c. Licansa numbar: 960000

29d. Data signed *(Month, Day, Yaar)*: May 25, 1998

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): J Todd Baldanza 4940 Eastern Avenue, Baltimore, MD

State Registrar

31. Data filad *(Month, Day, Yaar)*: MAY 28 1998

32. Registrar's Signatura: ▶ Julie Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 98 16500

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Mary A. Cermak	May 26, 1998	4:02 P.M.

4e Facility Name (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Death
Mariner Glen Burnie	Glen Burnie	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212--12--5607	1☐ M 2☒ F	78 Yrs.			Dec 10, 1919	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1631 Ceddox Street	21226	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th Grade		Home Maker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Nowakowski	Michalina Stelmach

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Frank J. Cermak / Son	1631 Ceddox Street Baltimore, Maryland 21226

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Holy Cross Cemetery	5/29/98	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Richard E. Davies	George J. Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Maryland 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. OBSTRUCTIVE JAUNDICE	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. CHOLELITHIASIS	
	Due to (or as a consequence of):	
	c. CIRRHOSIS LIVER, CRYPTOGENIC	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ANGINA

Ascites

SPLENOMEGALY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Richard E. D	DO 2519	5-27-98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Richard E Fisher 4710 Pennington Ave 21226

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 28 1998	Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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